WELCOME

1 Personal Information

Legal Name: First_____ M._____ Last _____

Prefer to be called _____ Birthdate_____ SS#_____

Whom may we thank for referring you? _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married/Partner ☐ Divorced ☐ Widowed ☐ Separated

Mailing Address _____

City _____ State _____ Zip_____

Employer _____ Occupation _____

Driver's License # or State ID (please present your picture ID) _____

2 Responsible Party

If other than SELF, please fill out the following:

Legal Name: First_____ M._____ Last _____

Birthdate_____ SS #_____ Driver's License #_____

Mailing Address _____

City _____ State _____ Zip_____

Employer _____ Occupation _____

3 Contact Information

Home Phone_____ Cell Phone_____

Work Phone_____ What number do you prefer to receive calls? _____

Email Address _____

Would you prefer to receive appointment confirmations or reminders for regular visits via text and/or email messages? ☐ Yes ☐ No

In the event of an emergency, who should we contact?_____

Relation_____ Contact Phone _____

4 Dental Insurance Information

Please provide us with your dental benefit card to copy for our records.

Have you or your family had dental claims submitted elsewhere during this benefit year? ☐ Yes ☐ No

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS # _____

Employer _____

Date Employed _____

Insurance Company _____

Group/Plan # _____

Insured/Subscriber ID _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS # _____

Employer _____

Date Employed _____

Insurance Company _____

Group/Plan # _____

Insured/Subscriber ID _____

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent/guardian if minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card ____ Visa ____ MC ____ Discover

_____ I wish to discuss the dental office's financial arrangements.

Late Charges

If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of $2.50 will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

_____ Initial

Annual Information Update:

Date_____ No Changes ☐ or Please update the following information _____

Date_____ No Changes ☐ or Please update the following information _____

Date_____ No Changes ☐ or Please update the following information _____