

PATIENT INFORMATION

PATIENT NAME	MALE	FEMALE	BIRTHDATE	SS#
STREET ADDRESS	CITY		STATE	ZIP
HOME PHONE #	CELL PHONE #		EMAIL ADDRESS	
SPOUSE'S NAME	SPOUSE'S DOB	SPOUSE'S SS#	SPOUSE'S EMPLOYER	
PATIENT'S EMPLOYER		PATIENT'S WORK PHONE #		
WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____				

INSURANCE INFORMATION

INSURED'S NAME	INSURED'S DOB	RELATIONSHIP TO PATIENT		
INSURED'S SS#	INSURED'S ID#	INSURANCE CO. NAME	GROUP #	
INSURED'S EMPLOYER		EMPLOYER ADDRESS		
DO YOU HAVE SECONDARY DENTAL INSURANCE? IF SO, PLEASE COMPLETE THE FOLLOWING.				
INSURED'S NAME	INSURED'S DOB	RELATIONSHIP TO PATIENT		
INSURED'S SS#	INSURED'S ID#	INSURANCE CO. NAME	GROUP #	
INSURED'S EMPLOYER		EMPLOYER ADDRESS		

PAYMENT POLICY

- Payment is expected at the time services are rendered. Unless other arrangements have been made. (As a service we will submit insurance claims and pretreatment estimates.)
- Dental insurance is intended to offset only a percentage of dental treatment. This insurance is a contract between you and your insurance carrier. The cost of services provided for you are your sole financial obligation.

I have read the above payment policy and hereby authorize the doctor to perform any treatment that may be indicated. I also understand that prior to treatment a full explanation will be given by the doctor or his staff. I agree to pay for all services rendered by this office.

Signature of responsible party

Date

May we: (please initial)

_____ Leave any messages on home phone or cell phone.

_____ Speak to spouse/parent regarding any treatment or fees associated with treatment.

Signature

Date: