PLEASE COMPLETE AND RETURN TO BUSINESS OFFICE

Personal Information

Name: Last First Middle

Address: Street or P.O. Box # City State Zip code

Phone Number: Home: Work:

Pager#: Cell Phone: Email Address:

Age: Yrs. Birth Date: Mo. Day Year Birthplace: ( )Married ( )Unmarried ( )Separated

Social Security No: (if child, parents) Driver's License No:

Occupation: Employer: How long employed? Address & Phone No:

Person responsible for bill: Age: Address: Relationship: Social Security No: Driver's License No:

Occupation: Employer: How long Employed?

Employer Address & Phone No:

Insurance Information

Insured Person's Full Name Date of Birth

Social Security Number Relationship to Patient Work Phone

Insurance Company Name Group or Union Name Group or Local Numbers

Employer's Name Full Address of Employer

Getting to Know You

1. Why did you select our practice? _____
2. Whom may we thank for referring you? _____
3. Is another member of your family or relative a patient in our practice? _____
4. Person to contact for emergency: _____ Phone: _____
5. When was your last dental visit? _____
6. When was the last time you had complete dental radiographs taken? _____ Name and Address of last Dentist: _____
7. Have you ever had any teeth removed? _____ How long have these teeth been missing? _____ Have these teeth been replaced? _____ How? ❒Bridge ❒Partial ❒Denture ❒Implants

Payment Alternatives

Please check appropriate box:

❒ 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.

❒ 2. Cash and personal checks are accepted as your treatments are provided.

❒ 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

❒ 4. Mastercard, Visa, Discover and American Express

❒ 5. For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party Relationship Date