Welcome

Thank you for selecting our dental healthcare team! We strive to provide you with the highest standards in care and comfort service. To help us meet all your dental healthcare need, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information

Name _____ Date _____

Wishes to be called _____ Date of Birth _____

□ Male □ Female □ Minor □ Single □ Married □ Divorced □ Widowed

Address_____

City _____ State_____ Zip _____

SS # _____ Email _____

Employer _____ Occupation _____

Referred By _____ May we Thank Them? _____

In the event of an emergency, whom should we contact?

Name _____ Relationship _____
Home Phone _____ Cell Phone _____ Work Phone _____

Telephone

Home Phone _____ Cell Phone _____

Work Phone _____ Ext # _____

May we leave a message with either a person or on voicemail on any of your numbers? □YES □NO

Where do you prefer to be contacted? □ Home □ Cell □ Work □ Email

Responsible Party

Who is responsible for the account?

Name _____ Date of Birth _____

Relationship to Patient _____ SS#_____ Driver's Lic # _____

Address _____

City _____ State_____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext # _____

Employer _____ Occupation _____

Dental Insurance Information

Primary Insurance	Secondary Insurance
Name of Subscriber _____	Name of Subscriber _____
Relationship to Patient _____	Relationship to Patient _____
Subscriber's Date of Birth _____	Subscriber's Date of Birth _____
Subscriber's SS# or ID# _____	Subscriber's SS# or ID# _____
Subscriber's Employer _____	Subscriber's Employer _____
Date Employed _____	Date Employed _____
Occupation _____	Occupation _____
Insurance Company _____	Insurance Company _____
Group # _____	Group # _____

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.

I give permission for any necessary: (please circle) FLUORIDE RADIOGRAPHS SEALANTS

Signature of Patient /Parent_____ **Date** _____

Financial Arrangements

Please put all account balances on my credit card:

□ Visa □ Mastercard □ Discover

Account Number _____

Expiration Date _____ CVV Code _____

Signature Date _____ Date _____