PATIENT INFORMATION

DATE: _____

NAME: _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS: _____
STREET APT. # CITY STATE ZIP

BIRTHDATE: _____ TELEPHONE: ☐ _____ ☐ _____
MO DAY YR. HOME OFFICE

PLACE OF EMPLOYMENT (OR SCHOOL): _____ GRADE _____ S.S. # _____

DENTAL INSURANCE CO.: _____ GROUP NO. _____

EMAIL ADDRESS: _____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

	FATHER (OR HUSBAND)	MOTHER (OR WIFE)
Name:	_____ LAST FIRST M	_____ LAST FIRST M
Address:	_____ STREET CITY STATE ZIP	_____ STREET CITY STATE ZIP
Telephone #:	_____ HOME # WORK #	_____ HOME # WORK #
Birthdate/SS #:	_____ MO DAY YR SS #	_____ MO DAY YR SS #
Employer:	_____ EMPLOYER	_____ EMPLOYER
Dental Insurance Co.:	_____ DENTAL INSURANCE	_____ DENTAL INSURANCE
Group #:	GROUP #	GROUP #

PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE:
☐ Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY/HOUSEHOLD IN CASE OF EMERGENCY

NAME _____ TEL # _____
LAST FIRST M

ADDRESSS _____
STREET CITY STATE ZIP

METHOD OF PAYMENT

Does Responsible Party currently have an account with this office? ☐ YES ☐ NO

If NO, please check one of the following:

☐ Payment in full at each appointment.
☐ Payment in full when billed. (Must complete credit application.)
☐ Monthly budget payments. (Prior arrangements must be made.)
☐ Credit Card number _____ Exp. Date _____

FINANCE CHARGE. If I do not pay the entire New Balance within 25 days of the monthly billing date a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on the account.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

_____
STATE DRIVER'S LICENSE NUMBER

X _____ DATE _____

☐ Adult Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian