Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet your entire dental healthcare needs please fill out this form completely in ink. If you have any questions or need assistance please ask us – we will be happy to assist you.

Today's Date: _____

Patient Information

Name_____ Birth Date_____ Social Security # _____
Address_____ City_____ State_____ Zip_____
Home Phone #_____ Cell Phone #_____
E-Mail Address _____

Check Appropriate Box: Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐
If Student, Name of School/College_____
Patient's or Parents' Employer_____ Work Phone #_____
Business Address_____ City_____ State_____ Zip_____
Spouse or Parent's Name_____ Employer _____ Work Phone _____
Whom May We Thank for Referring You_____
Person to Contact in Case of Emergency_____ Phone #_____

Responsible Party

Address_____ Phone #_____
Driver's License #_____ Birth Date_____ Financial Institution_____
Employer_____ Work Phone_____ Social Security_____

Is this person currently a patient in our office? Yes ☐ No ☐

For your convenience, we offer the following methods of payment. Please check the option you prefer.
Cash/Credit Card/Check ☐ 5% Pre-payment discount ☐ Patient Financing ☐

Insurance Information

Name of Insured _____ Relationship to Patient_____
Date of Birth_____ Social Security #_____Date of Employment_____
Name of Employer_____ Union or Local# _____ Work Phone _____
Address of Employer_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____ Policy/ID#_____
Insurance Co. Address_____ City_____ State_____ Zip_____

CONSENT:

1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I understand and authorize the doctor to disclose the above to other healthcare providers as needed for my ongoing care.
3. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____
4. I authorize this dental practice to use my phone number, mailing address and/or email address to send me dental related information and practice promotional information.
5. Lastly, I understand that all responsibility for payment for dental services provided in this office for me or my dependants are mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½% finance chare (18%APR) may be added to my account. In the event that collection proceedings are employed, I further agree that I will be responsible for any collection fees, attorney fees, and court cost associated with it.

Patient: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to Patient_____