WELCOME TO OUR PRACTICE.

Thank you for selecting our office for your dental care needs.
We are committed to providing you with the best care possible.

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PATIENT INFORMATION

(confidential)

Date _____

Name _____
LAST FIRST MIDDLE

Home Phone(___) _____ Cell Phone(___) _____ Business Phone(___) _____
INCLUDE AREA CODE INCLUDE AREA CODE INCLUDE AREA CODE

Address _____ City _____ State_____ Zip _____
MAILING ADDRESS

SS# or Patient ID _____ Date of Birth _____

Sex: M F Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact:_____ Relationship:_____ Home Phone(___) _____ Cell Phone(___) _____
INCLUDE AREA CODE INCLUDE AREA CODE

Patient Employer _____ Address _____ Phone(___) _____

Spouse_____ Phone (___)_____ Birth Date _____ SS#_____

Spouse Employer_____ Address _____ Phone(___) _____

Whom can we thank for referring you? _____

If you are completing this form for another person, what is your relationship to that person? _____ _____
YOUR NAME RELATIONSHIP

RESPONSIBLE PARTY

Name of Person Responsible for this account _____ Relationship to patient_____

Address _____ City _____ State _____ Phone _____

Birth Date_____ Social Security # _____

Employer _____ Work Phone _____

Is this Person currently a patient in our office? ___yes ___no

PLEASE COMPLETE OTHER SIDE

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Birth Date_____ Social Security # _____ Work Phone _____

Name of Employer _____

Address _____

Insurance Company _____ Group # _____ Policy ID# _____

Insurance Co. Address_____ City_____ State_____ Zip _____

Do you have a secondary dental insurance policy? ____yes ____no If yes, please provide card.

FINANCIAL AGREEMENT

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or appropriate health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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. Payment for services is due in full at the time service is provided. In the event your account is delinquent and placed with a collection agency you are responsible for the collection fee of 35% of the account balance as liquidated damages, and if an attorney is hired to collect, after maturity, 15% of unpaid principal and interest owing on said account as attorneys' fees.

Signature of patient (parent if minor) _____ Date _____