PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ DATE_____
FIRST MI LAST

ADDRESS_____ CITY_____ STATE_____ ZIP_____

E-MAIL_____ SS#_____ BIRTHDATE_____ PHONE #_____

MOBILE PHONE #_____ CIRCLE APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED

IF COLLEGE STUDENT, F.T./P.T., NAME OF SCHOOL_____

PATIENT'S/PARENT'S 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

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE #_____ DRIVER'S LICENSE #_____ D.O.B._____ SS#_____

EMPLOYER_____ WORK PHONE #_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

A Finance charge will be assessed on any outstanding balance using a periodic rate of 1.5% - annual percentage rate of 18% - The outstanding balance is that part of the balance remaining unpaid after payments and credit adjustments have been subtracted. Accounts sent to collections are liable for all costs. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____ (X)_____

DENTAL INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

D.O.B._____ SS#_____ DATE OF EMPLOYMENT_____

NAME OF EMPLOYER_____ UNION OR LOCAL #_____ WORK PHONE #_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

INSURANCE CO._____ TEL #_____ GRP#_____ POLICY/ID#_____

INS. CO. ADDRESS_____ CITY_____ STATE_____ ZIP_____

AMOUT OF DEDUCTIBLE?_____ MAXIMUM ANNUAL BENEFIT?_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

D.O.B._____ SS#_____ DATE OF EMPLOYMENT_____

NAME OF EMPLOYER_____ UNION OR LOCAL #_____ WORK PHONE #_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

INSURANCE CO._____ TEL #_____ GRP#_____ POLICY/ID#_____

INS. CO. ADDRESS_____ CITY_____ STATE_____ ZIP_____

AMOUT OF DEDUCTIBLE?_____ MAXIMUM ANNUAL BENEFIT?_____