WELCOME!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible.
If you have any questions, or we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name _____ (If child, parent/guardian name) _____
Last name *First name* *Initial*

Birthdate_____Sex_____Age_____ Soc. Sec. #_____
Home Address_____City _____State_____Zip_____
Home Phone_____ Work Phone_____ Cell phone_____
E-Mail_____ Drivers License #_____

How did you hear about our practice? _____
Employer_____Occupation_____How long there? _____May we call?_____
Employer Address_____City _____State_____Zip_____

Spouse's Name (Or other parent/guardian)_____Soc. Sec. #_____
Spouse's Employer_____Occupation_____How long there? _____May we call?_____
Spouse's Employer Address_____City _____State_____Zip_____

If patient is a student: Name of school/college: _____City & State_____Full time or part time?_____

Primary Insurance:

Name of Insured _____
Birthdate_____Relationship to patient_____
Address (if different from patient)_____
Dental Insurance Co._____Phone_____
Social Security #_____ Subscriber ID #_____
Group, Contract or Local or union #_____

Additional Insurance:

Name of Insured _____
Birthdate_____Relationship to patient_____
Address (if different from patient)_____
Dental Insurance Co._____Phone_____
Social Security #_____ Subscriber ID #_____
Group, Contract or Local or union #_____

Copayments:

To accept insurance, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check:

CIRCLE ONE: Visa MasterCard Discover Amex
Account#_____Expiration date_____Name on card_____
☐ Credit Card ☐ Debit Card ☐ ATM ☐ Voided check attached.

In Case of Emergency:

Name and City of primary care physician _____
Someone we may contact, not living with you: _____Phone #'s (home, work, cell)_____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I further authorize this office to charge my credit card to cover any unpaid fees not paid by insurance within 60 days. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

I have received a copy of this office's Notice of Privacy Practices.

Signature _____Date_____
Patient or Responsible Party