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PATIENT INFORMATION

Patients Name _____ Birthdate_____ Male/Female

Home Address _____

Home Phone_____Work Phone_____e-mail address_____

Best way to contact you_____

Employer _____ Address_____

If patient is a minor, who is legally responsible? _____

In case of emergency, who should be notified? _____Phone _____

Who may we thank for referring you? _____

Responsible party to bill _____ Relationship _____

Address _____Social Security # _____

Dental Insurance Co. _____ Policy/Group #_____ Phone_____

Policy Holder ID _____ Date of Birth _____

We accept assignment of benefits. This means that by signing below you want your insurance company to directly reimburse us for the services you receive. Your deductible and copay are due on the date that treatment is rendered. We will estimate your portion as closely as possible, but until payment is received from your insurance company, it is just an estimate. It is important that you understand that your insurance coverage is a contract between your employer, your insurance company and yourself. We will assist you in the billing of your insurance claim and in dealing with your insurance company, but be aware that the ultimate responsibility for charges incurred lies with you.

Patients that fail to pay on time will be charged 1.5% monthly on all overdue balances, and will be charged for all costs associated with collecting past due amounts.

We offer extended payment plans through CareCredit – and accept all major credit cards.

Signed_____ Date _____