PATIENT INFORMATION

DATE ______________________

NAME ______________________ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

LAST FIRST MI

ADDRESS ______________________

STREET APT # CITY STATE ZIP

BIRTH DATE ______________ TELEPHONE ______________

MONTH/DATE/YEAR HOME# WORK/CELL#

PLACE OF EMPLOYMENT ______________________ SS# ______________

IF FULL TIME STUDENT, SCHOOL NAME ______________________ GRADE ________

DENTAL INSURANCE CO. ______________________ GROUP # ______________

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

Whom may we thank for referring you to our office? ______________________

FAMILY INFORMATION

Father (or husband)	Mother (or wife)
Last First MI	*Last First MI*
Street City State Zip	*Street City State Zip*
Home Tel Work Tel	*Home Tel Work Tel*
Birthdate SS#	*Birthdate SS#*
Employer	*Employer*

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of immediate Family/Household

Name ______________________

Address ______________________

City/St/Zip ______________________

Telephone # ______________________

AUTHORIZATION

I hearby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hearby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/ medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X ______________________

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Date Driver's License #

PAYMENT OPTIONS

Please Initial your preference:

A. ___ *Pay in full at time of treatment - check or cash*

B. ___ We accept MC/Visa/Amex

C. ___ 1/2 down then $200/month *withdrawn directly from your bank account* -interest charged

D. ___ Care Credit Financing - ask for application

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is the annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.