PATIENT INFORMATION RECORD

DATE: _____

PATIENT INFORMATION:

Name

_____

_____

Address _____ City_____ State_____ Zip Code_____

Home Phone _____ Work Phone_____Cell Phone _____

Birth Date _____ Social Security #_____

Name of parent or guardian if patient is a minor_____

Is this patient currently enrolled in school or college? Circle: Yes or No

Name of school or college patient attends:

_____

Please list names of family members previously seen in this office

_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____Relationship _____Date of Birth_____ S.S.#_____

Address_____City_____State_____ Zip Code _____

Home Phone _____Work Phone _____ Cell Phone _____

Employer

_____

_____

SPOUSE INFORMATION

Name

_____

_____

Employer _____Work Phone _____Cell Phone_____

OTHER

Name of contact person not living with you _____Relationship_____

Complete Address _____Phone _____

Please tell us how you were referred to our office (another patient or doctor, phone directory, etc.) _____

PAYMENT POLICY

You are responsible to see that your total bill is paid. As a courtesy to you, our patient, we will gladly "estimate" your benefits and file treatment with your insurance carrier. Your insurance co-pay will be collected the day of service. However, please understand that this dental office is not associated with any insurance company and cannot be responsible for benefits that will or will not be paid on your treatment. After 60 days you are responsible for any unpaid balance (even insurance that is pending).

We offer our patients a number of payment options including cash, checks, Mastercard, American Express, Visa and most debit cards. For patients wanting to finance their treatment, we will be glad to put you in contact with a dental finance company, or you may seek financing at your bank.

Patients with insurance will be asked to pay an ESTIMATE of the fee not covered by their insurance the day of treatment. Adjustments, refunds or requests for payment may need to be made after your insurance settles, as any fees quoted are "estimates only." A finance charge of 1.5% per month will be added to your account on unpaid balances.

DENTAL INSURANCE INFORMATION

Insured's Name _____Insured's Date of Birth _____Insured's S.S.#_____

Insured's Address_____

_____ Insured's Employer_____ Insurance Company_____

Do you have dual coverage? ( Please Circle: Yes or No)

Insured's Name _____Insured's Date of Birth _____Insured's S.S.#_____

Insured's Address_____

_____

Insured's Employer_____ Insurance Company_____

ALL THE INFORMATION ON THE FRONT AND BACK OF THIS PAGE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____DATE _____