# PATIENT INFORMATION

**Today's Date:**_____

**Name:**_____
First MI Last
**Preferred name:**_____

**Birth Date:** _____/_____/_____ **Age:**_____
**SS#:** _____
____Male ____Female ____**Child**
____ Single____ Married____ Divorced ____ Other

**Home Address:**_____
Apt #
_____
City State Zip
**Patient or Parent Phone Numbers:**
Home phone # ( )_____
Work phone # ( )_____
Cell phone # ( )_____
**Email Address:**_____
**Employer:** _____
**Employer Address:** _____
_____
City State Zip
How long there?_____
Occupation:_____
**Person Responsible for Account:**
_____
**Address if different:** _____
_____
City State Zip
**Other family members seen by us:**
_____

**Primary Dental Insurance**

Insurance Co. Name: _____
Insurance Co. Address: _____
_____
City State Zip
Insurance Co. Phone #: ( ) _____
Employer/Group Name: _____
Group/Plan or Policy # _____
Policy Holder Name: _____
Relationship to patient: _____
Policy Holder Birth Date: _____/_____/_____
Policy Holder Ins. ID #: _____

**Secondary Dental Insurance**
**____Yes ____No**

Insurance Co. Name: _____
Insurance Co. Address: _____
_____
City State Zip
Insurance Co. Phone #: ( ) _____
Employer/Group Name: _____
Group/Plan or Policy # _____
Policy Holder Name: _____
Relationship to patient: _____
Policy Holder Birth Date: _____/_____/_____
Policy Holder Ins. ID #: _____

## Referral Information

*Whom may we thank for referring you to our practice?*

Name of person or office referring you to our practice: _____
Referred by: ____Yellow Pages ____Online Yellow Pages ____Location ____ Our Website
_____ Door Bags ____ Insurance Co. List ____ Other: _____

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. **All emergency dental services or any dental services performed without previous financial arrangements, or services not covered 100% by your dental insurance must be paid for at the time services are performed.**

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Not every service may be a covered benefit in all insurance plans or contracts and insurance companies may calculate their reimbursements in a manner that may not fully cover your charges. In the event this is the case, please contact your insurance company for an explanation.** Please inform this office of any changes to your insurance coverage.

I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I also grant permission to you or your assignee, to telephone me to discuss matters related to this form and to confirm my dental appointments as necessary.

**We require 24 hours notice if you need to change or cancel your appointment. Failure to do so may result in a charge for the broken appointment. There will be a $25.00 charge for all returned checks.**

**I have read the above conditions of treatment and payment and agree to their content.**

_____ **Date** _____ **Relationship to patient** _____
Signature of Patient, Parent/Guardian or Responsible Party