



Date _____

Patient Information:

Patient Name _____ Birthday _____ Home Phone _____

Cell Phone _____ Soc. Sec. # _____ Email: _____

Mailing Address _____ City _____ State/Zip _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's Employer _____ Work Phone _____

Other family members seen by The Dentists' Office _____

Spouse or Parent/Guardian's Name _____ Date of Birth _____

Spouse or Parent/Guardian's Employer _____ Work Phone _____

Person to Contact in Case of Emergency (not living in the same home) _____

Relationship _____ Phone Number _____

Responsible Party (makes decisions regarding treatment, scheduling and finances) _____

Relationship _____ Soc. Sec. # _____ Date of Birth _____

Insurance Information:

Policy Holder Name _____ Relationship to Patient _____

Phone Number _____ Date of Birth _____ Soc. Sec. # _____

Name of Employer _____ Insurance Company _____

Group Number _____ Member ID Number _____

Does the patient have a secondary insurance policy? Yes No

Policy Holder Name _____ Relationship to Patient _____

Phone Number _____ Date of Birth _____ Soc. Sec. # _____

Name of Employer _____ Insurance Company _____

Group Number _____ Member ID Number _____

Payment Policy:

Payment in full is due at the time of service. We cannot guarantee any estimated coverage when billing insurance. You are ultimately responsible for any remaining amount unpaid by insurance. We are happy to offer a 5% courtesy adjustment for all treatment paid at the time of service with cash or check. There will be a \$30 service fee on any returned checks. All unpaid balances are subject to a 10% processing fee and will incur a 1.5% monthly finance charge. All delinquent balances must be paid prior to incurring any new charges. In order to comply with The Red Flag Rule, our office will be requiring the following information in order to be treated in our facility. (A) A valid photo ID of the patient or their responsible party issued by a local, state or federal agency Or (B) Two forms of non-photo ID, one of which is issued by a state or federal agency, as well as a water or utility bill or other form identifying the current address. If the case where a patient is unable to present proper identification their appointment will be rescheduled. In emergency situations patients will be referred to the nearest hospital for care.

Signature of Patient, Parent or Guardian

Date