

PATIENT INFORMATION

Patient Name

LAST

FIRST

MIDDLE INITIAL

Home Address

STREET

APT. #

CITY

STATE

ZIPCODE

Phone Number

HOME #

WORK #

CELLULAR #

EMAIL

Social Security # _____ - _____ - _____

Driver License # _____

Date of Birth ____/____/____

Age _____

Sex _____Female _____Male

Marital Status: _____Single _____Married _____Separated
 _____Divorced _____Widowed

Occupation _____
 Place of Employment _____
 # of Years Employed _____

If patient is a minor, please give parent/legal guardian's name.

FATHER

DATE OF BIRTH

SOCIAL SECURITY #

MOTHER

DATE OF BIRTH

SOCIAL SECURITY #

Please provide information of the nearest relative **NOT** living with you.

NAME

RELATIONSHIP

STREET

APT#

CITY

STATE

ZIP CODE

HOME PHONE #

WORK PHONE #

CELLULAR PHONE #

REFERRAL INFORMATION

How did you hear about us?

____Yellow Pages

____Friend/Relative

____Sign

____Employee

____Employer

____Insurance Company

____Television Commercial

____Mail Coupon

____Flyers

____Bill Board

____Radio Ad. (Station _____)

____Newspaper

____Community Magazine

____Health Fairs/ Screenings

____Other (Specify) _____

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

**** FINANCIAL CONSENT FOR SERVICES ****

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care, and the financial responsibility on the part of each patient must be determined before treatment. If you have insurance and have assigned benefits to the dentists, your balance and charges are estimates based on the portion your insurance may not cover. After the insurance has or has not paid, **you will be billed for the remaining balance.** I also agree to pay a service charge of 20% or \$20 (whichever is greater) on the unpaid balance, and all attorney/collection fees will be charged to this account if this account is placed for collection.

By your signature, you have authorized this office to complete your insurance form for you, render service to you or your child, sign your name on claim forms and acknowledge receipt of our Privacy Notice. I grant my permission to you or your assignee to telephone me at home/work/mobile phone/e-mail to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

 Signature of Patient/Parent/Legal Guardian

 Date