

PATIENT INFORMATION



Patient

<i>Last Name</i>		<i>First</i>		<i>MI</i>	<i>Male</i> <input type="checkbox"/>	<i>Married</i> <input type="checkbox"/>
<i>Preferred Name (Nickname)</i>		<i>Birthdate</i> - -		<i>SS#</i> - - -	<i>Female</i> <input type="checkbox"/>	<i>Single</i> <input type="checkbox"/>
<i>Address</i>		<i>Apt #</i>	<i>Home Phone</i> () -		<i>Cell Phone</i> () -	
<i>City</i>	<i>State</i>		<i>Zip</i>	<i>Home email</i>		

Employer

<i>Name</i>			
<i>Address</i>		<i>Suite #</i>	<i>Work Phone</i> () - <i>Ext.</i>
<i>City</i>	<i>State</i>	<i>Zip</i>	<i>Work email</i>

Insurance

<i>Subscriber's Name</i>		<i>Birthdate</i> - -	<i>SS#</i> - - -
<i>Carrier Name</i>			
<i>Address (PO Box)</i>		<i>Suite #</i>	<i>Phone</i> () - <i>Ext.</i>
<i>City</i>	<i>State</i>	<i>Zip</i>	<i>Website</i>

If you have dental insurance, we will gladly assist you in the processing of your claims to maximize the benefits to which you are entitled. HOWEVER, your insurer has a contract between your employer and you, not the dentist, so **you are responsible for all charges** incurred.

Parent Information (if patient is a minor.)

***NOTE:** We are required to have on file below the parent who brings the child in for care.

<i>Last Name</i>		<i>First</i>		<i>MI</i>	<i>Married</i> <input type="checkbox"/>	<i>Single</i> <input type="checkbox"/>
<i>Address</i>		<i>Apt #</i>		<i>Birthdate</i> - -	<i>SS#</i> - - -	
<i>City</i>	<i>State</i>	<i>Zip</i>	<i>Home Phone</i> () -			
<i>Employer</i>						
<i>Employer Address</i>			<i>Suite #</i>	<i>Work Phone</i> () - <i>Ext.</i>		
<i>City</i>	<i>State</i>	<i>Zip</i>	<i>Work email</i>			

Signature

<i>How did you hear about our office?</i>						
<i>Today's payment will be by:</i> <i>Cash</i> <input type="checkbox"/> <i>Check</i> <input type="checkbox"/> <i>Visa</i> <input type="checkbox"/> <i>M/C</i> <input type="checkbox"/> <i>Discover</i> <input type="checkbox"/> <i>AmEx</i> <input type="checkbox"/>						

By signing below, I certify that all of the above statements are true to the best of my knowledge, that I understand I am responsible for all charges incurred (regardless of any insurance coverage,) and I agree to pay all collection costs associated with late or non-payment of this account:

Signature _____ **Date** _____
(If patient is a minor, only the parent bringing the child in for care may sign)