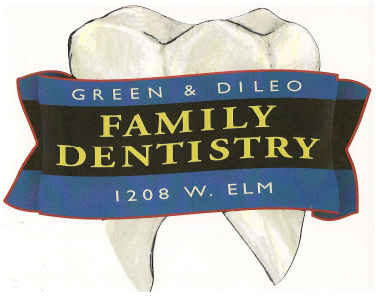

Welcome

Thank you for selecting our dental healthcare team! The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. To help us meet all your dental healthcare needs, please fill out this form completely.

ABOUT YOU

Today's Date:_____

Name: _____
Last First Mi

I prefer to be called:_____ ☐ Male ☐ Female

Birthdate: ____/____/____ SS #:_____-_____-_____

Mailing Address: _____

_____
City State Zip

Hm #:(____)_____Cell #:(____)_____

Wk#:(____)_____Ext:_____ DL #:_____

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Employer:_____

Employer's Address:_____

How long There?_____Occupation:_____

Where & When are best times to reach you?_____

Other Family members seen by us:_____

Previous /Present Dentist:_____

Dentist Ph#:(____)_____Last Visit Date:_____

ABOUT SPOUSE

Name: _____
Last First Mi

Birthdate: ____/____/____ SS #:_____-_____-_____

Cell #:(____)_____DL #:_____

Employer:_____

Wk#:(____)_____-_____Ext:_____

EMERGENCY INFO

Contact: _____
Last First Mi

Hm #:(____)_____Cell #:(____)_____

Wk#:(____)_____Ext:_____ Relationship:_____

Personal Physician: _____

Phone #: (____)_____Date of last visit: _____

INSURANCE INFO

Primary Dental Insurance

Insurance Co.:_____

Insurance Phone #: (_____)_____-_____

Employer: _____

Insured's Name:_____
Last First Mi

Birthdate: ____/____/____ SS #:_____-_____-_____

Insured's ID #:_____Group #:_____

Relationship to Patient: _____

Secondary Dental Insurance

Insurance Co.:_____

Insurance Phone #: (_____)_____-_____

Employer: _____

Insured's Name:_____
Last First Mi

Birthdate: ____/____/____ SS #:_____-_____-_____

Insured's ID #:_____Group #:_____

Relationship to Patient: _____

Assignment of Benefits

_____ I hereby authorize assignment of my insurance rights & benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.
(Initial)

RESPONSIBLE PARTY

Name: _____
Last First Mi

Billing Address:_____

Relationship:_____ SS #:_____-_____-_____

Hm #:(____)_____Cell #:(____)_____

Wk#:(____)_____Ext:_____ DL #:_____

Employer:_____

Payment Method: ☐ **Cash** ☐ **Check** ☐ **Credit Card**

Card #_____

Exp Date: _____ **V Code:** _____

FINANCIAL POLICY

- **Our Policy requires <u>PAYMENT IN FULL for all services rendered at the time of visit</u>, unless prior arrangements have been made. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fee, collection agency fees, interest charges and any other expenses incurred in collecting your account.**
- **I authorize the staff to perform any necessary services needed during diagnosis & treatment. I also authorize the provider to release any information required to process insurance claims.**
- **I understand the above information & guarantee this form was completed correctly to the best of my knowledge & understand it is my responsibility to inform this office of any changes to the information I have provided.**

Signature_____**Date**_____/_____/_____

☐ **Adult Patient** ☐ **Parent or Guardian** ☐ **Spouse**