

Patient

Name _____ DOB ___/___/___ SS# ___-___-___
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Marital Status _____
Cell/Pager # _____ E-Mail Address _____ Sex: M / F
Driver License # _____ Employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Spouses Name _____ DOB ___/___/___ Employer _____
Emergency Contact _____ Phone# _____
Last Dental Exam _____ Previous Dentist _____
Who referred you _____ What is your chief complaint _____

PRIMARY DENTAL INSURANCE

Subscriber Name _____ Relation to patient _____
SS# ___-___-___ DOB ___/___/___ Employer _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company Name _____ Group # _____
Insurance Address _____ City _____ State _____ Zip _____
Phone # _____ Yearly Deductible _____ Yearly Maximum _____

SECONDARY DENTAL INSURANCE

Subscriber Name _____ Relation to patient _____
SS# ___-___-___ DOB ___/___/___ Employer _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company Name _____ Group # _____
Insurance Address _____ City _____ State _____ Zip _____
Phone # _____ Yearly Deductible _____ Yearly Maximum _____

Who is financially responsible _____
Payment - Cash () Check () Visa/MasterCard ()

Full payment or your expected portion is due the day of service, unless arrangements have been made in advance.

You agree that if it becomes necessary to forward your account to our collection agency, that, in addition to the amount owed, you will also be responsible for reasonable cost of collection, including attorney fees.

Signature _____ Date _____

