WELCOME

FEES THAT ARE ESTIMATED NOT TO BE COVERED BY YOUR INSURANCE ARE DUE AT TIME OF TREATMENT

METHOD FOR PAYMENT: CASH_____ CHECK _____ CREDIT CARD_____

NAME_____

Last First Middle Marital Status

RESIDENCE_____

Street City State Zip

MAILING ADDRESS_____

PO Box City State Zip

HOME PHONE_____WORK PHONE_____CELL PHONE_____

SOCIAL SECURITY #____-____-____BIRTH DATE____/____/____EMPLOYER_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE_____

Preferred Pharmacy _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

INSURED'S NAME_____BIRTH DATE____/____/____ SOCIAL SECURITY # ____-____-____

INSURANCE CO._____GROUP #_____

INSURANCE CO. ADDRESS_____

INSURED'S EMPLOYER_____RELATIONSHIP TO PATIENT_____

SECONDARY DENTAL INSURANCE

INSURED'S NAME_____BIRTH DATE____ /____ /____ SOCIAL SECURITY# ____ -____ -____

INSURANCE CO._____GROUP #_____

INSURANCE CO. ADDRESS_____

INSURED'S EMPLOYER_____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE_____ ADDRESS_____ _____PHONE_____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET. I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE DENTAL MATERIALS FACT SHEET DATED OCTOBER 17, 2001. I CERTIFY ALL THE ABOVE INFORMATION IS TRUE AND COMPLETE AND I AM THE PATIENT OR AUTHORIZED REPRESENTATIVE OF THE PATIENT. I AUTHORIZE ALL REQUIRED INFORMATION TO MY INSURANCE COMPANY AS NECESSARY TO PROCESS ANY CLAIMS AND AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PROVIDER. A SERVICE FEE WILL BE CHARGED ON ALL RETURNED CHECKS. IF THE ACCOUNT IS PLACED WITH AN ATTORNEY AND/OR COLLECTION AGENCY ALL REASONABLE COSTS AND/OR LEGAL FEES SHALL BE BORNE BY THE UNDERSIGNED. ALL PATIENT INFORMATION IS HELD IN CONFIDENCE. ANY PATIENT INFORMATION NO LONGER NEEDED BY THIS OFFICE WILL BE SHREDDED AND DISPOSED OF PROPERLY.

SIGNED:_____DATE:_____/_____/_____