Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____

If college student, F.T/P.T., name of school _____ City _____ State _____

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

X_____
Signature of patient (or parent, if minor)

Office Policies

FEES - The fee for your treatment is based on the complexity of your case. You will be informed of the fee after your examination.

PAYMENT – It is our policy that payment for all services rendered be made in full AT or BEFORE the completion of treatment. We realize that some dental treatment may be of an emergency nature, and that patients may not always be prepared for unexpected dental expenses. To assist you in this regard, we gladly accept VISA, MASTERCARD.

DENTAL INSURANCE – If you believe that your treatment is covered by a dental insurance policy, we will be happy to assist you in completing the necessary forms. Please understand that while this is done for your convenience, **we consider each patient to be responsible for their entire balance regardless of their insurance coverage.**

If your insurance carrier will reimburse you directly, we ask that your account with our office be paid in full when treatment is rendered.

MISSED APPOINTMENTS – Confirmed appointments require 24 hour notice if you are unable to be present. You will be assessed a MISSED APPOINTMENT FEE of $50.

X_____ _____

Signature of patient (or parent, if minor) **Date**