WELCOME

PERSONAL INFORMATION

NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____
STREET OR P.O. BOX# CITY STATE ZIP CODE

BIRTH DATE:_____SOCIAL SECURITY NO:_____STATUS:☐SINGLE☐MARRIED☐CHILD☐OTHER

TELEPHONE NUMBERS:_____
HOME WORK CELL E-MAIL

EMPLOYER_____

HOW DID YOU HEAR ABOUT US/REFERRED BY? _____

PERSON RESPONSIBLE FOR BILL

NAME:_____RELATIONSHIP TO PATIENT_____

ADDRESS &TELEPHONE:_____

SOCIAL SECURITY NO:_____EMPLOYER_____WORK PHONE NO:_____

INSURANCE INFORMATION

PRIMARY
INSURED PERSONS FULL NAME:_____

SOCIAL SECURITY NO:_____BIRTH DATE:_____RELATIONSHIP TO PATIENT_____

INSURANCE COMPANY NAME:_____EMPLOYER:_____

GROUP/POLICY NO:_____

SECONDARY
INSURED PERSONS FULL NAME:_____

SOCIAL SECURITY NO:_____BIRTH DATE:_____RELATIONSHIP TO PATIENT_____

INSURANCE COMPANY NAME:_____EMPLOYER:_____

GROUP/POLICY NO:_____

AUTHORIZATION AND RELEASE

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services at the time of service, unless other arrangements have been made with the business manager.
- If you have dental insurance, we want you to receive full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover when you see the doctor. Remember, however, that you are responsible for the account if the ins. company, for any reason, does not honor their commitment to you and to us.
- Missed or cancelled appointments without 24 hour notice are subject to a $25 fee.
- I authorize the doctor and staff to perform any necessary services during diagnosis and treatment.
- I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

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SIGNATURE RELATIONSHIP TO PATIENT DATE