DATE: ____________________

Patient Information

Name: ____________________ (Last) ____________________ (First) ________ (Initial) MARRIED / SINGLE / MINOR / MALE / FEMALE

Address: ____________________ (Street) ____________ (Apt. No.) ____________ (City) ____________ (State / Zip)

Birthdate: ______ (mo.) ______ (day) ______ (yr.) Telephone: ____________ (home) | ____________ (office) | ____________ (cell)

Place of Employment (or School): ____________________ Grade: ________ S.S. Number ____________________

Dental Insurance Co.: ____________________ Group No. ____________________

Has any member of your family ever been treated in our office? ______ Yes ______ No

Whom may we thank for referring you to our office? ____________________

Responsible Party Info.

IF MARRIED LIST SPOUSE
IF MINOR LIST PARENT OR RESPONSIBLE PARTY INFORMATION

	FATHER (OR HUSBAND)	MOTHER (OR WIFE)
NAME:	Last / First / M	Last / First / M
ADDRESS:	Street / City / State / Zip	Street / City / State / Zip
TELEPHONE:	Home No. / Work No.	Home No. / Work No.
BIRTHDAY | SS NO.	Mo. / Day / Yr. / S.S. No.	Mo. / Day / Yr. / S.S. No.
EMPLOYER:	Employer	Employer
DENTAL INS. CO.	Dental Ins.	Dental Ins.
GROUP NO.	Group No.	Group No.

Person Responsible for Account

Check One: ☐ Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

Emergency Contact

Name: ____________________ Tel. Ph. ____________________

Address: ____________________

Method of Payment

Does Responsible Party have an account with this office? ☐ Yes ☐ No

☐ **Payment in full at each appointment.**

☐ **Have Insurance. Will pay my estimated portion when services are rendered.**

FINANCE CHARGE. If I don't pay the entire new balance within 25 days of the monthly billing date, a Finance Charge will be added to the account for the current monthly billing period. The Finance Charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $134.00) which is an Annual Percentage Rate of 18% applied to the last month's balance. In case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Signature of Responsible Party

I understand that my Insurance policy is a contract between me and my Insurance company and that Dental Office can not guarantee payment of my claim.

X ____________________ Date: ____________________

☐ Adult Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

ANEST.	MED. ALERT

PATIENT INFORMATION