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Welcome

Date: _____

Name: _____ Preferred name: _____
Last First Middle

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ Date of Birth: _____ Social Security: _____ Single ☐ Married ☐

Primary Phone #: ☐HOME ☐CELL _____ Secondary Phone #: ☐HOME ☐CELL _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Your E-mail address: _____

In case of an emergency who may we contact? _____ Phone: _____

Who may we thank for referring you? _____

Dental Insurance

Primary

Insurance Company: _____

Insurance Company Address: _____

_____

Insurance Company Phone: _____

Policy Holders Name: _____

Relationship to Patient: _____

Policy Holders Employer: _____

Policy Holders SS#: _____

Policy Holders Birthday: _____

Insurance Card ID#: _____

Group #: _____

Secondary

Insurance Company: _____

Insurance Company Address: _____

_____

Insurance Company Phone: _____

Policy Holders Name: _____

Relationship to Patient: _____

Policy Holders Employer: _____

Policy Holders SS#: _____

Policy Holders Birthday: _____

Insurance Card ID#: _____

Group#: _____

I UNDERSTAND THAT THE PORTION OF MY TREATMENT NOT COVERED BY INSURANCE IS DUE AND PAYABLE AT EACH VISIT. IF MY INSURANCE COMPANY HAS NOT PAID THEIR PORTION WITHIN 60 DAYS OF BEING PROPERLY BILLED. I UNDERSTAND THAT THE BALANCE WILL BECOME DUE AND PAYABLE FROM ME.

A MISSED APPOINTMENT IS A LOSS TO EVERYONE. A NO-SHOW FEE WILL BE CHARGED FOR MISSED APPOINTMENTS, LESS THAN 24 HOUR NOTICE.

I UNDERSTAND THERE WILL BE A $25.00 SERVICE CHARGE FEE FOR ANY RETURNED CHECK. I ALSO AGREE TO PAY ANY INTEREST, COLLECTION COST AND ATTORNEY FEES INCURRED TO EFFECT COLLECTION ON THIS ACCOUNT.

I UNDERSTAND AND AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, AND/OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR FOR A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS, AND PERFORM ANY TREATMENT THAT MAY BE INDICATED.

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____ _____
SIGNATURE OF RESPONSIBLE PARTY DATE RELATIONSHIP TO PATIENT(S)

(OVER)