PATIENT'S NAME:

FIRST MIDDLE LAST

DATE OF BIRTH: **SOCIAL SECURITY #:** **DRIVERS LICENSE:**

( ) MALE ( ) FEMALE ( ) MR. ( ) MRS. ( ) MISS. ( ) MS. ( ) DR. ( ) MARRIED ( ) SINGLE ( ) DIVORCED ( ) WIDOWED

STREET ADDRESS: CITY: STATE: ZIP:

HOME #: CELL #: WORK# EMAIL:

PATIENTS EMPLOYER: ADDRESS: OCCUPATION:

SPOUSES NAME: CELL #: WORK #:

IN CASE OF AN EMERGENCY WHO MAY WE CONTACT? PHONE #:

HOW DID YOU HEAR ABOUT US? ( ) FRIEND ( ) FAMILY ( ) INTERNET ( ) DRIVING BY ( ) POSTCARD ( ) AD - which one

WHO MAY WE THANK FOR REFERRING YOU: ADDRESS:

PRIMARY DENTAL INSURANCE

NAME OF INSURANCE CO:

INSURANCE CO. PHONE #:

SUBSCRIBERS NAME:

INSURANCE ID #:

GROUP #:

SUBSCRIBER'S SS#:

SECONDARY DENTAL INSURANCE

NAME OF INSURANCE CO.:

INSURANCE CO. PHONE #:

SUBSCRIBERS NAME:

INSURANCE ID #:

GROUP #:

SUBSCRIBER'S SS#:

SUBSCRIBERS RELATIONSHIP TO PATIENT: ( ) SELF ( ) SPOUSE ( ) PARENT ( )DEPENDANT ( ) GUARDIAN

TO PROCESS YOUR CLAIM WE NEED THE SUBSCRIBERS EMPLOYERS NAME, ADDRESS AND PHONE NUMBER

EMPLOYER: PHONE #: OCCUPATION:

STREET ADDRESS: CITY: STATE: ZIP:

All estimated co-pays are due when services are rendered. If no insurance then full payment is due at the time of your dental appointment. Any remaining co-pays, after your insurance company has processed your claim, are due upon receipt of your bill. To avoid late fees we must receive your payment by the date on your statement. We greatly appreciate timely payments. Thank you.

Appointments are reserved specifically to your needs. We do not double book and we cannot fill a no show or last minute cancellation(s). A **24 HOUR Notice** is a respectable time to notify us if you need to change your reserved appointment. If this courtesy is not extended to our office we reserve the right to assess **a fee of $75.00**, which in no way covers our costs, to the appropriate account(s).

For your convenience we offer the following methods of payment: ( ) Cash ( ) Personal Check ( ) Credit/Debit/Flex Cards ( ) Care Credit

SIGNATURE: **DATE:**