



## Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Title: \_\_\_\_\_ Preferred Name : \_\_\_\_\_

Gender:  Male  Female      Family Status:  Married  Single  Child  Other

Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile) \_\_\_\_\_

Emergency Contact Name and Phone Number: \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

### Responsible Party Information

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Title: \_\_\_\_\_ Gender:  Male  Female      Family Status:  Married  Single  Other

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile) \_\_\_\_\_

Address: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

**Primary Dental Insurance Information**

Name of Insured: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_ ID# \_\_\_\_\_ Group#: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Patient's relationship to insured:     Self    Spouse     Child     Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

*Please let us know if you have secondary dental insurance.*

**Consent for Services**

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will accept assignment of benefits from most insurance companies, however, the patient is always responsible for any balance their insurance company does not cover.

I understand that any fee estimate for this dental care can only be extended for a period of ninety days from the date of the patient's examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree to pay all costs and reasonable attorney fees if account goes into collection.

I have read the above conditions of treatment and payment and agree to their consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_