PATIENT INFORMATION DATE:_____

NAME _____ MARRIED__ SINGLE__MALE__FEMALE__
LAST FIRST M

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE_____ _____ _____
HOME# WORK# CELL#

MAY WE LEAVE MESSAGE? HOME WORK CELL
(Please circle)

EMAIL ADDRESS_____ BIRTHDATE_____

PLACE OF EMPLOYMENT_____OCCUPATION_____SS#_____

DENTAL INSURANCE CO._____SUBSCRIBER NAME_____

SUBSCRIBER #_____GROUP #_____

FAMILY INFORMATION:

HUSBAND (or Father if child)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE WORK TELEPHONE

_____
BIRTH DATE SS#

_____
EMPLOYER OCCUPATION

_____
DENTAL INSURANCE CO. SUBSCRIBER# GROUP#

WIFE (or Mother if child)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE WORK TELEPHONE

_____
BIRTH DATE SS#

_____
EMPLOYER OCCUPATION

_____
DENTAL INSURANCE CO SUBSCRIBER# GROUP

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 dental/ medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/ medical histories and other information about my dental treatment to third party payers and/or health professionals. I understand that where appropriate credit bureau reports my be obtained.

If I do not pay the entire balance within 25 days of the monthly billing date, a SERVICE CHARGE will be added to my account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last months balance. In the 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 of this account or future outstanding accounts.

x_____DATE_____

PERSON REPSONSIBLE FOR ACCOUNT

Please circle one:

Patient/ Spouse/ Father/ Mother/ Other

OTHER FAMILY MEMBERS ON ACCOUNT

_____

_____

_____

_____

_____

EMERGENCY CONTACT

PHONE_____NAME_____