PLEASE PRINT

PATIENT INFORMATION

MR / MRS. / MISS / DR — LAST NAME	FIRST NAME	MIDDLE	MARTIAL STATUS

SOCIAL SECURITY #	DATE OF BIRTH	SEX	HOME PHONE #	CELL PHONE #

LOCAL ADDRESS — STREET	APT. #	CITY	STATE	ZIP

YOUR OCCUPATION	EMPLOYED BY	BUSINESS PHONE #

SPOUSE'S NAME	SPOUSE'S SOCIAL SECURITY #	SPOUSE'S DATE OF BIRTH

SPOUSE'S OCCUPATION	EMPLOYED BY	SPOUSE'S BUSINESS PHONE #

NEAREST FRIEND / RELATIVE NOT LIVING IN THE SAME HOUSE	RELATIONSHIP TO PATIENT	PHONE #

WHO IS YOUR GENERAL DENTIST ?	WHO REFERRED YOU TO THIS OFFICE ?

PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH THE RECEPTIONIST.

OUR OFFICE ACCEPTS CASH, CHECK, ALL CREDIT CARDS & works with Capital One and Care Credit finance programs.

_____DATE _____
Signature

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YOUR INSURANCE BENEFITS AND OUR OFFICE

Our office extends the courtesy of working with you and your Insurance Company to help you receive benefits due you for services provided in this office. An appropriate form will be provided for each service that can be filed to your insurance company.

Our office can file, on your behalf, a pre-determination for benefits available to you on any recommended treatment and assignment can be accepted with finances set up on your pre-determined responsibility.

Most insurance policies are designed to help you with your expenses and rarely pay the entire fee. In all instances – since the services are rendered to the patient, the obligation for payment of the entire fee is the responsibility of the patient -- not the Insurance Company.

PLEASE GIVE YOUR CARD TO THE RECEPTIONTIST. YOUR SIGNATURE BELOW AUTHORIZES THIS OFFICE TO FILE YOUR INSURANCE ON YOUR BEHALF

_____ **Date**

_____ **Signature - Patient / Responsible party**