



Patient: (Dr., Master, Miss, Mr., Mrs., Ms.)

Date _____

First _____ MI _____ Last _____
 Preferred Name: _____ Male _____ Female _____ DOB ____ / ____ / ____
 Address _____ Apt # _____
 E-Mail Address _____
 City _____ State _____ Zip Code _____
 Phone: Home # (____) _____ Cell # (____) _____
 Employer _____ Address _____
 Work # (____) _____ SS# _____
 Dentist _____ Physician _____ Referred by _____

Have any family members or relatives been treated in our office? Please name: _____

Guarantor (Person financially responsible for patient)

Patient relation to Guarantor: _____ Self _____ Spouse _____ Child _____ Parent _____ Other _____

If other than self, please complete:

Guarantor (Dr., Master, Miss, Mr., Mrs., Ms.) _____

 First _____ Last _____
 Address _____ Apt # _____
 City _____ State _____ Zip Code _____
 Phone: Home # (____) _____ Cell # (____) _____
 Employer _____ Address _____
 Work # (____) _____ SS# _____

Insured Party Information

Primary Insured Party Info (cardholder)

 First _____ Last _____
 Address _____

 City _____ State _____ Zip _____
 Relation: _____ self _____ spouse _____ child _____ other _____
 SS# _____ - _____ - _____ ID# _____
 DOB ____ / ____ / ____ Male _____ Female _____

Primary Dental

Insurance Co. _____
 Address _____
 Ins. Phone # (____) _____
 Group # _____



Secondary Insured Party Info

First _____ Last _____
Address _____

City _____ State _____ Zip _____
Relation: _____ self _____ spouse _____ child _____ other _____
SS# _____ - _____ - _____ ID# _____
DOB _____ / _____ / _____ Male _____ Female _____

Secondary Dental

Insurance Co. _____
Address _____
Ins. Phone # (____) _____
Group # _____

It is the policy of our office that full payment is due at the time services are rendered. We accept MasterCard, Visa, and Discover, American Express cards, debit cards as well as cash and personal checks.

If a payment plan would be desirable to you, please let us know, as we do work with a company that provides interest-free financing for dental services.

As a courtesy to you, we will be happy to submit your claim to your insurance company. Please remember that insurance is considered a method of reimbursing the patient for fees charged to you by our office.

We welcome and encourage discussion of services and fees prior to treatment in order to avoid misunderstandings.

Also, as a courtesy to our office, if, for any reason you cannot keep your appointment, please call our office 48 hours in advance. There will be an \$80 charge for a missed appointment.

If you have any questions, we will be happy to assist you.

My signature authorizes the release of information requested by the insurance company which is necessary to process my claim. I understand that I am financially responsible for all charges.

Signature: _____ Date: _____