

PATIENT DATA

(Please select one) ODr. OMr. OMrs. OMs. OMiss

(Prefer to be called, e.g., "John," Mr. Jones") _____

First Name _____ Last Name _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Date of Birth _____

Occupation _____

Employer Name and Address _____

Is there someone else (e.g. parent for minor) who will be financially responsible for this account? If so, please list

Name of Responsible Party _____ SSN _____ DOB _____

SECONDARY INSURANCE PRIMARY INSURANCE

Primary Insurance Carrier _____

Name of Insured _____

Insured's SSN _____ Insured's DOB _____

Insured's Employer _____

Insurance Mailing Address _____

Insurance Telephone Number () _____ Group or Plan Number _____

Secondary Insurance Carrier _____

Name of Insured _____

Insured's SSN _____ Insured's DOB _____

Insured's Employer _____

Insurance Mailing Address _____

Insurance Telephone Number () _____ Group or Plan Number _____

Pharmacy Name _____ Pharmacy Phone Number () _____

Family Dentist _____

Whom may we thank for referring you to us? _____

In case of emergency, whom may we contact? _____

Emergency Contact Phone Number _____

I understand that my account is payable at the time of service, unless other arrangements have been made for payment. I also understand that I assume responsibility for payment of any charges not covered by insurance, and that I will be liable for all cost of collection including attorney fees, together with interest accruing at the rate of 1% per month, with a minimum monthly charge of \$2.50, for accounts 90 days or more overdue. A charge of \$15.00 will be charged for all returned checks.

Signature _____ Date _____