

# Patient Information (CONFIDENTIAL)

Patient # \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_  
 Date \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
 Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 If Patient is a Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Whom May We Thank for Referring You? \_\_\_\_\_  
 Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

# Responsible Party

Relationship to Patient \_\_\_\_\_  
 Name of Person Financially Responsible for this Account \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Is this Person Currently a Patient in our Office?  Yes  No

# Dental Insurance Information

Relationship to Patient \_\_\_\_\_  
 Name of Insured \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING:

Relationship to Patient \_\_\_\_\_  
 Name of Insured \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I understand that I am financially responsible for payment in full for dental services provided in the office to myself (or my dependent). I understand that payment is due at the time service is rendered and that a finance charge of 1 1/2% per month (18% APR) will be assessed on any balance remaining after 90 days from the date of service. In the event of default, I/we promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorneys fees.

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