Chart # _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: Last_____ First_____ MI_____ Date_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child Other_____ Social Security#_____ Birth Date_____

Phone (Home):_____ (Work)_____ Ext:_____ Best time to call:_____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Address:_____

Street Apartment#

_____

City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:_____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #:_____ Birth Date_____

Phone (Home):_____ (Work)_____ Ext_____ Best time to call_____

Address_____

Street Apartment

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Occupation:_____

Address:_____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: Last_____ First_____ MI_____ Is insured a patient? ☐ yes ☐ no

Insured's Birth Date:_____ ID#:_____ Group#:_____

Insured's Address: Street_____ City_____ State_____ Zip Code_____

Insured's Employer Name:_____

Address: Street_____ City_____ State_____ Zip Code_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:_____

Address: Street_____ City_____ State_____ Zip Code_____

Secondary

Name of Insured: Last_____ First_____ MI_____ Is insured a patient? ☐ yes ☐ no

Insured's Birth Date:_____ ID#:_____ Group#:_____

Insured's Address: Street_____ City_____ State_____ Zip Code_____

Insured's Employer Name:_____

Address: Street_____ City_____ State_____ Zip Code_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:_____

Address: Street_____ City_____ State_____ Zip Code_____

Consent For Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or gurdian_____ Date_____ Relationship toPatient_____

Signature of guarantor of payment/responsible party_____ Date_____ Relationship to Patient_____