

PATIENT INFORMATION

Dr.
Mr.
Mrs.
Miss
Ms.

Last Name First Name Middle Name Date of Birth

Mailing Address Street City State Zip

Street Address (If Different) Street City State Zip

() _____ () _____ () _____
Home # Cell # Work # Patient Social Security #

Patients Employer Employers Address City State Zip

General Dentist Referred By (If Different)

Contact Person In Case of Emergency (Or Nearest Relative Not in Home) () Home# () Work#

Complete Next 3 Lines if Responsible Person is Different

Person Responsible For Account Relationship To Patient

Responsible Person's Address City State Zip () Home#

Social Security # Responsible Person () Work #

Insurance Company Name **Policy Holder Subscriber/Employee** **Policy Number Or Certificate Number**

1. _____

2. _____

3. _____

To avoid misunderstandings regarding dental insurance, we wish our patients to know that ALL PROFESSIONAL SERVICES ARE CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OR FEES. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. PATIENTS ARE EXPECTED TO TAKE CARE OF THEIR FEES AS SERVICES ARE RENDERED.

PREFERRED METHOD OF PAYMENT: CASH CHECK CREDIT CARD
(MASTERCARD/VISA/DISCOVER/AMERICAN EXPRESS)

Signature

Date