

**I PATIENT INFORMATION**

Patient Name \_\_\_\_\_ ☐ Male ☐ Female ☐ Other  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_  
Email \_\_\_\_\_  
Person Responsible for Account Payment \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Whom may we thank for this referral \_\_\_\_\_

**II EMPLOYMENT INFORMATION (IF MINOR, PERSON RESPONSIBLE FOR ACCOUNT)**

Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Work Phone (\_\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Work Phone (\_\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_

**III PAYMENT OPTIONS**

Payment for today's visit and your future visits is due at the time of treatment. We are sensitive to the fact that some people may not be able to pay cash for their treatment; therefore, we offer several alternative options for your convenience. Please indicate which method you will use to settle your account and/or insurance co-payment:

\_\_\_\_\_ **Cash or Check**      \_\_\_\_\_ **MasterCard or Visa**

Insurance: As a courtesy extended to our patients, we will gladly process your primary insurance claim, estimate your deductible, co-payment, and any portion not covered by your insurance. Estimated "co-payments" are due at time of treatment. Exact insurance payment is subject to carrier approval; therefore, the amount due our office is subject to change. A final statement showing actual insurance payment will be forwarded to you. Any balance is due upon receipt. As dental care providers, our relationship is with you and not your insurance company; therefore, insurance payment disputes are the patient's responsibility.

Name of Insurance Company \_\_\_\_\_  
Policy/Group # \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_ DOB \_\_\_\_\_

**IV ADDITIONAL INSURANCE**

If you have additional insurance, please provide the above information on reverse of this form.

I authorize release of any information related to this claim  
And/or treatment plan. I understand that I am responsible  
for all costs of dental treatment.

I hereby authorize payment directly to the above named  
dentist for insurance benefits otherwise payable to me.

\_\_\_\_\_  
Signed (Patient or parent if minor)      Date

\_\_\_\_\_  
Signed (Patient or parent if minor)      Date

I further understand that a 1½% finance charge (18% annually) will be added to any balance over 90 days. In the event of default I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

\_\_\_\_\_  
Signed (Patient or parent if minor)      Date