

# WELCOME

## ABOUT YOU 1

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
CITY STATE ZIP

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
CITY STATE ZIP

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

## ACCOUNT INFO 3

Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
CITY STATE ZIP

Drivers License #: \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Payment method:  Cash  Check

\_\_\_\_\_ I hereby authorize assignment of my insurance rights and benefits directly to the provider for I services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company I (if offered at this office).

## INSURANCE INFO 2

Primary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_  
CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_  
CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## IN EVENT OF EMERGENCY 4

Whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Medical Doctor's Phone #: (\_\_\_\_) \_\_\_\_\_

- ❖ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- ❖ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees up to 40%, interest charges and any other expenses incurred in collecting your account.
- ❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment and to contact me by land line or by mobile phone. I also authorize the provider to release any information required to process insurance claims.
- ❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

Initials \_\_\_\_\_

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

Adult Patient  Parent or Guardian  Spouse

### UPDATE

(OFFICE USE)

Initials \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_