

Date

Date

Patient Information:				
Patient Name		Birthday	Home Phone	
Cell Phone	Soc. Sec. #		Email:	
Mailing Address		City	State/Zip	
Check Appropriate Box: ☐ M	linor □ Single □ Married □ [Divorced 🗆 Wide	owed Separated	
Patient's Employer			Work Phone	
Other family members seen I	by The Dentists' Office			
Spouse or Parent/Guardian's	Name		Date of Birth	
Spouse or Parent/Guardian's Employer			Work Phone	
Person to Contact in Case of	Emergency (not living in the sam	ne home)		
Relationship	Phone Number			
Responsible Party (makes de	cisions regarding treatment, sch	eduling and finan	ces)	
Relationship	Soc. Sec. # _		Date of Birth	
Insurance Information:				
Policy Holder Name			Relationship to Patient	
Phone Number	Date of Birth		Soc. Sec. #	
Name of Employer	In	surance Company	·	
	Member ID Number			
	ondary insurance policy? Yes			
Policy Holder Name			Relationship to Patient	
			Soc. Sec. #	
			·	
	Member ID Number			
Payment Policy:				
	time of service. We cannot guara	antee anv estimat	ed coverage when billing insurance. You are	
·	=		happy to offer a 5% courtesy adjustment for all	
			rvice fee on any returned checks. All unpaid balances	
•			ge. All delinquent balances must be paid prior to	
	=	•	ce will be requiring the following information in order	
= :	• •	=	ible party issued by a local, state or federal agency	
			agency, as well as a water or utility bill or other form	
			t proper identification their appointment will be	
rescrieduled. In emergency s	situations patients will be referre	ed to the hearest i	iospital for care.	

Signature of Patient, Parent or Guardian