

• Personal Information •

Name: _____ Date of birth: _____ Age: _____

Home address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email address: _____ Single Married Divorced Widowed

Employer: _____ Occupation: _____

Employer's address: _____

Spouse's name: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Person financially responsible: _____ D.L. # _____

Former dentist: _____ Date of last visit: _____

Whom may we thank for your referral?: _____

Your children's names and ages: _____

• Insurance Information •

Primary insurance company: _____ Name of policy holder: _____

Policy holder's social security #: _____ Policy holder's date of birth: _____

Employer: _____ Group #: _____

Secondary insurance company: _____ Name of policy holder: _____

Policy holder social security: _____ Policy holder's date of birth: _____

Employer: _____ Group #: _____

We will be happy to prepare the necessary forms to help you obtain your benefits from your insurance company. We do not, however, render our services on the basis that insurance companies will pay all of our fees. Each fee is individual for the individual patient. You, the patient, are fully responsible for any amount not covered by insurance or prepayment program. We allow thirty (30) days from the date of services to receive your insurance payment. There will be 1% monthly interest charged for accounts ninety (90) days past due. Please be aware that any insurance follow-up is the patient's responsibility.

Signature: _____

Date: _____