DATE:_____

PATIENT:_____
LAST FIRST M.I.

MARITAL STATUS: MARRIED_____ SINGLE_____ BIRTH DATE _____

PATIENT RESIDENCE:_____
Street

_____
City State Zip Code

PATIENT PHONE #:_____

PATIENT S.S. #:_____

PERSON RESPONSIBLE FOR PAYING ACCOUNT:_____

ADDRESS & PHONE NUMBER OF THAT PERSON IF DIFFERENT THAN ABOVE:_____

_____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? NAME AND PHONE:_____

_____

DENTAL INSURANCE COMPANY:_____

NAME OF INSURED:_____

DATE OF BIRTH:_____/_____/_____ S.S. # OF INSURED:_____

INSURED PLACE OF EMPLOYMENT:_____

PATIENT INFORMATION **SPOUSE INFORMATION**

_____
Firm

_____
Bus. Address

_____
City/Zip Code

_____
Bus. Phone

_____
Present Position

REFERRED BY:_____

LAST DENTAL VISIT:_____

PURPOSE OF THIS VISIT:_____

I agree to pay for all professional fees and treatment at the time of service, or my portion not covered by dental insurance, for myself, or above named patient, unless other financial arrangements are approved. I also agree to pay for all costs of collection, including attorney fees, and court cost, should additional means of collection be required. In addition, my signature on this form is my acknowledged authorization for the Dr. to seek a Credit Report if credit is extended.

Signature Date

_____ _____