

Please Complete and Return to the Business Office

Personal Information	Name: Last			First			Middle			
	Address: Street or P.O. Box #			City			State Zip code			
	Work:			Cell Phone:			Email Address:			
	Age: Yrs.		Birth Date: Mo. Day Year			Birthplace:			<input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Separated	
	Social Security No: (if child, parents)				Driver's License No:					
	Occupation:		Employer:			How long employed?		Address & Phone No:		
	Person responsible for bill:		Age:	Address:			Relationship:	Social Security No:		
								Driver's License No:		
	Occupation:		Employer:			How long Employed?				
Insurance Information	Insured Person's Full Name						Date of Birth			
	_____						_____			
	Social Security Number			Relationship to Patient			Work Phone			
	_____			_____			_____			
Insurance Company Name			Group or Union Name			Group or Local Numbers				
_____			_____			_____				
Getting to Know You	1. Why did you select our practice? _____				5. When was your last dental visit? _____					
	2. Whom may we thank for referring you? _____				6. When was the last time you had complete dental radiographs taken? _____					
	3. Is another member of your family or relative a patient in our practice? _____				Name and Address of last Dentist: _____					
	4. Person to contact for emergency: _____ Phone: _____				7. Have you ever had any teeth removed? _____ How long have these teeth been missing? _____ Have these teeth been replaced? _____					
					8. How? <input type="checkbox"/> Bridge <input type="checkbox"/> Partial <input type="checkbox"/> Denture <input type="checkbox"/> Implants					
Payment Alternatives	<b>Please check appropriate box:</b>									
	<input type="checkbox"/> 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.				This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.					
	<input type="checkbox"/> 2. Cash and personal checks are accepted as your treatments are provided.									
	<input type="checkbox"/> 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you.									
	<input type="checkbox"/> 4. MasterCard, Visa, Discover, and/or American Express									
<input type="checkbox"/> 5. For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.										

**FOR ALL PATIENTS**

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party

Relationship

Date