Patient Name: _____Date:_____
First Middle In. Last

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Other Phone:_____

Patient Date of Birth:_____ Patient Social Security #:_____ Status: M S W D

Patients Employer _____

E-Mail Address _____ Do You Prefer Contact By: E-Mail / Phone

RESPONSIBLE PARTY / INSURANCE INFORMATION

Name of Parent / Subscriber:_____

Date of Birth:_____ Social Security #:_____ WK phone:_____

Employer:_____ Insurance Name:_____

Group #:_____ Phone #:_____Other Insurance: Y N

Referral Information

Whom may we thank for referring you to our practice? □ another patient, friend □ another patient, relative
□ Yellow Pages □ Newspaper □ Work □ Brochure □ Insurance □ Location □ Other

Reason for Today's Visit:_____Date of last Dental Care:_____

CONSENT FOR SERVICES AND USE AND DISCLOSURE OF HEALTH INFORMATION

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Regardless of any dental insurance a patient may have, the full treatment fees are the responsibility of the patient, not the insurance company or the practice. Full payment of our fees is due at or before the time of treatment. A full explanation of our office policies is included in this packet for your review.

I grant my permission to your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read this form, agree to its terms, and certify I've provided all information completely and accurately.

_____ Date_____ Relationship to Patient_____
Signature of patient, parent or guardian

_____ Date_____ Relationship to Patient_____
Signature of guarantor of payment/responsible party

I, _____ (please print name) have been provided with the Notice of Privacy Practices provided by this office. I give my consent to this office for use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.
Signature:_____Date:_____