Today's date _____

PATIENT NAME_____ DATE OF BIRTH_____

____ Mr____ Mrs ____ Miss____ Ms____ Dr ____ Male ____ Female

Marital Status: _____ Married _____ Single_____ Divorced_____ Widowed

Address _____ City _____

Zip Code _____ SS# _____

Telephone: Home ( ) _____ Work ( ) _____

Cell ( ) _____

Where Do You Prefer We Call To Confirm Appointments? _____

In Case Of Emergency, Please List The Name Of Your Nearest Relative Who Does Not Live With You:
Name _____ Relationship _____

Address _____

Telephone: Day _____ Evening _____

Whom May We Thank For Referring You? _____

Relationship _____ Telephone: _____

_____

Who is responsible for payment of this account?

____ Self ____ Spouse____ Father____ Mother ____Other _____

Name _____

Address _____

Telephone: Day _____ Evening_____

Self:
Employee name: _____
Employed By: _____
Position:_____
Employer Address: _____
Work Telephone: _____
SS#_____ Date of Birth: _____
Address: _____
Telephone: _____

Insurance Company: _____
Address: _____
Telephone: _____
Group#: _____ ID#:_____

Spouse:
Employee name: _____
Employed By: _____
Position: _____
Employer Address: _____
Work Telephone: _____ Cell _____
SS#_____ Date of Birth: _____
Address: _____
Telephone: _____
Insurance Company: _____
Address: _____
Telephone: _____
Group#: _____ ID#:_____

Payment is due at or before time of service. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to this office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize any release of information, including the diagnosis and records of treatment or examination rendered, to my insurance company.
To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health history of if my medications change, I will inform the Doctor of Dentistry at my next appointment. I understand and agree that I am responsible for payment of this account and that account is payable on date of service. Any credit granted shall be paid within 90 days or in accordance with any written agreement. I agree that if I am delinquent of above terms that the credit grantor may add late payment fees not to exceed 1 ½% per month (18% annum) or $5.00 per month (whichever is greater). In event of default, I agree to pay reasonable collection charges and/or attorney fees. I authorize, where appropriate and necessary, Credit Bureau reports to be obtained.

Signature of Guarantor _____ Date _____