NAME: Last First Middle | Home Phone

ADDRESS: Street or P.O. Box # City State Zip Code | Work Phone

SPOUSE'S NAME | PATIENT BIRTHDATE | BIRTHPLACE | ( ) Married ( ) Unmarried ( ) Separated | SOCIAL SECURITY NO. (if child, parent's)

OCCUPATION | EMPLOYER OR SCHOOL ADDRESS | HOW LONG EMPLOYED

PERSON RESPONSIBLE FOR BILL (if other than patient) | WORK PHONE: | HOME PHONE | RELATIONSHIP

OCCUPATION | EMPLOYER | ADDRESS

1. Why did you make this appointment? ____________
2. Who told you about us, or how did you find out about us? ____________
3. Is a member of your family or a friend a patient in our practice? ____________
4. Emergency Contact: ____________

   Phone: ____________
5. When was your last dental visit? ____________

   What for? ____________
6. Have you ever had any teeth removed? ____________

   How long have these teeth been missing? ____________
7. Has the space been replaced? ____ ☐ Bridge ☐ Partial

Insurance Information

(Disregard if you have no dental insurance)

INSURED PERSON'S FULL NAME | BIRTHDATE

SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT | WORK PHONE

INSURANCE COMPANY NAME | GROUP OR POLICY NUMBER

EMPLOYER NAME | FULL ADDRESS OF EMPLOYER

Method of Payment

1. Payment is expected as services are rendered.
2. We accept mastercard, visa, cash, and personal checks.
3. 5% Courtesy discount for paying the full estimated cost of the entire treatment plan as follows:
   1) Over $3500.00
   2) Must be paid before or at the time of 1st appointment
   3) Does not apply to procedures covered by insurance with exception of patient paying and insurance reimbursing patient.
4. If you have dental insurance we can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept your insurance payment as partial payment. This means that you are responsible for your deductible and the portion not covered by your insurance at the time of your visit. Remember that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

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 deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY | RELATIONSHIP | DATE