(Please be completely honest. We respect total confidentiality.)

☐ T/N ☐ F

Personal Information

Mr./Mrs./Ms/Miss _____
last *first* *middle initial*

What name shall we call you? _____ Date of Birth __/__/__ Home Phone ( ) _____

Home address _____ City _____ State _____ Zip _____

Billing address _____ City _____ State _____ Zip _____

Driver lic# _____ State _____ Social Security# ___-___-___

Employer _____ Occupation _____ Work Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Spouse name _____ Spouse work phone ( ) _____

Do you have dental insurance? _____ Parent/guardian name if patient is a minor _____

Person to contact in case of emergency _____ Relation _____ Telephone ( ) _____

Who may we thank for referring you? _____

To avoid any misunderstandings regarding your dental insurance, we wish our patients to know that all **professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees.** We do not render services on the basis that the insurance companies will pay our fees unless a pre-determination of benefits has been established. We will assist you in filing all insurance forms. **Payment is due when services are rendered unless other arrangements have been made.** If you must change a scheduled appointment, please inform us as soon as possible. If we are not notified before 3:00 p.m. the working day prior to your appointment, then we may regrettably, charge your account.

I hereby authorize Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. I understand that responsibility for payment for dental services provided in this office for me or my dependents is mine, due and payable at the time services are rendered.

Signature of patient or responsible party _____ **Date** _____

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(please complete both sides)