Patient Name:_____ Employer:_____

Patient Address: _____ City, State, Zip:_____

Social Security #:_____ DOB: _____ Age:_____

Marital Status:_____ Sex:_____ Spouse/Parent: _____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email Address:_____

Physician: _____ Phone #: _____

In case of Emergency:_____Phone #: _____

Person Responsible for Account:_____

Do you have ***DENTAL INSURANCE***: YES ☐ NO ☐

Policy Holder Information: Name:_____

Policy Number:_____

Subscriber I.D.:_____

Subscriber SS#:_____

Do you have ***Secondary DENTAL INSURANCE***: YES ☐ NO ☐

Name:_____

Policy Number:_____

Subscriber I.D.:_____

Subscriber SS#:_____

Were you referred to our Office:_____

Is any member of your family a current patient here:_____

I, the undersigned patient or legally responsible party, authorize treatment to be rendered and assume financial responsibility. I acknowledge that all non-current balances and accounts over 90 days will be submitted to a third-party collection agency, and any fees incurred by the collection agency will be my responsibility on any unpaid balance. The cost incurred in collecting this account, including court costs, agency fees and attorney fees will be added to the balance due. I acknowledge that in keeping with the Health Insurance Portability & Accountabilty Act of 1996 (HIPPA), the release of health care records can be done for the purposes of treatment, payment, or health care operations. I have been given the opportunity to review this office's "Notice of Privacy Practices" and also assign to the doctor all insurance payments, should claims be filed as assigned benefits.

Date: _____Signature of Person Responsible for Account:_____