Welcome!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible. If you have any question or we can help you in any way please feel free to ask.

Patient Information (Confidential):

Name_____ (If child, parent/ guardian name)_____
Last name First Name
Birth Date_____ Sex____ Age_____ Soc Sec #_____
Home Address_____City_____State____ Zip_____
Home Phone_____ Work Phone _____Cell Phone _____E-mail_____
Drivers License #_____

Employer_____Occupation_____ How long there?_____ May we call? _____
Employer Address_____City_____State_____ Zip_____

Spouse's Name_____Soc.Sec.#_____
Spouse's Employer_____ How long there? ____May we call?_____
Spouse's Employer Address_____City_____ State_____Zip_____

If patient is a student: Name of College_____ City &State_____Full or part time_____

Primary Insurance:

Name of Insured_____
Birthdate _____
Address (if different from patient)_____
Dental Insurance Co._____
Social Security #_____
Group, Contract #_____

Copayments:

To accept insurance payments, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check.
___MC ___Visa Account #_____Exp. Date_____PIN_____Name on Card_____
___Credit Card ___Debit Card ___Voided Check attached

In case of emergency:

Name and City of primary care physician_____
Someone we may contact, not living with you:_____Phone #s_____

Authorizations:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my record to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.
I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collections costs if this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.
I have received a copy or read this office's Notice of Privacy

_____Date_____
Signature of patient or responsible party