NAME_____ **BIRTHDATE** _____ **SOCIAL SEC #** _____

ADDRESS_____**CITY**_____**STATE**___ **Zip**_____

HOME PHONE # _____ ___**WORK PHONE #**_____

CELL PHONE # _____ **EMAIL ADDRESS** _____

STATUS: **MINOR** ___ **SINGLE**___ **MARRIED**___ **DIVORCED**____ **SEPARATED** _____**OTHER**_____

SPOUSE'S NAME _____

REFERRED BY _____

GENERAL DENTIST _____

EMPLOYER: _____ **HOW LONG** _____

OCCUPATION _____

PRIMARY DENTAL INSURANCE

COMPANY NAME _____ **GROUP #** _____

ADDRESS _____**CITY** _____ **STATE** _____**ZIP** _____

INSURED'S NAME: _____ **RELATIONSHIP TO PATIENT** _____

INSURED'S DATE OF BIRTH _____ **INSURED'S SOCIAL SEC #:** _____

INSURED'S ID #_____**INSURED'S EMPLOYER** _____

SECONDARY DENTAL INSURANCE

COMPANY NAME _____ **GROUP #** _____

ADDRESS _____**CITY** _____ **STATE** _____**ZIP** _____

INSURED'S NAME: _____ **RELATIONSHIP TO PATIENT** _____

INSURED'S DATE OF BIRTH _____ **INSURED'S SOCIAL SEC #:** _____

INSURED'S ID #_____**INSURED'S EMPLOYER** _____

Person ultimately responsible for account if different from above:

*Name*_____

*Relation:*_____

*Address*_____

*City*_____ *State*___ *ZIP*_____

SS: _____

Home Phone _____

Work Phone _____

Our policy requires payment in full for all service rendered at the time of the visit, unless other arrangements have been made. If an account is not paid within 60 days of the date of service and no financial arrangements have been made, finance charges of 1.15% per month will accrue. If an account is not paid within 90 days, you will be responsible for legal fees, collection fees, interest charges and any other expenses incurred in collecting your account.

I understand the above information and guarantee that this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information provided.

Signature_____ **Date**_____