Patient Information Form

Name:_____ Maiden name(other)_____

Social Security #:_____ Male or Female____ Date of birth:_____

Drivers License State & #:_____

Home Address: _____City:_____State: ____ Zip_____

Home Phone:_____ Cell Phone: _____

*Employer:_____ Work#:_____Email:_____**Would like***

***to be contacted by email for reminders and confirmations** Yes ___ No ___ Can we Text? Yes___ No___*

Spouse's Name:_____Employer:_____Work Ph:_____

Spouse Birthdate: _____ Social Security #:_____

Nearest Relative not living with you: _____Phone:_____

Nearest Friend not living with you: _____Phone:_____

Physician: _____Phone: _____

Landlord: _____ Phone: _____

***Whom may we contact in the case of emergency**:_____ Ph:_____*

Whom may we thank for referring you to us?_____Phone:_____

Primary Dental Insurance:_____Policy holder:_____

ID #_____ Social Security #_____ Grp #_____ Date of Birth_____

Secondary Dental Insurance:_____Policy holder: _____

ID #_____ Social Security # _____Grp#_____Date of Birth_____

Who is responsible for this bill? _____ Relationship to patient:_____

Responsible party's address (if different)_____

Responsible party's social security # (if different)_____ Birthdate: _____

Responsible party's employer:_____

I will be paying today by cash ___check____ credit card (Mastercard/Visa/Discover/Care Credit)____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I understand that you reserve the right to bill for missed or broken appointments and that you waive that right if given at least 24 hours notice. You also reserve the right to impose a 2% per month interest on unpaid balances due 60 days. It is the policy of the office to expect payment at time of service. In the event that it becomes necessary to turn an account over to outside collection, I agree to pay all costs related to collection, to include court costs and attorney fees that may ensue. This also may include collection charges not in excess of 50% of the unpaid balance. I have read all the information and completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature ***Date***

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