Today's Date_____

Patient Information Form

Patient Name: First	MI Last	Nickname	
Address: Street	City	State Zip	
Phone: Home	Work	Mobile	
E-mail address			
By Providing your e-mail address you agree	to receive (check one or both) 🗆 Appoi	intment Reminders □ Practice Newsletter	
What is your preferred method of contact?	□ Home Phone □ Work Phone □ M	obile Phone 🗆 E-Mail	
Social Security Number	Date of Birth		
Drivers License #	State		
Patient Employed By	Occupation	Phone	
Address: Street	City	State Zip	
Sex □ Male □ Female Marital Status	□ Married □ Single □ Divorced □	Separated □ Widowed	
In case of emergency, who should be notified	!?		
Relationship to Patient	Home Phone	Mobile Phone	
Is the patient a Minor? ☐ Yes ☐ No Fu	ll-time Student □ Yes □ No Name	of School	
Name of Responsible Party: First		Last	
Date of BirthRelati	ionship to Patient 🗆 Self 🗆 Spouse	□ Parent □ Other	
If patient is a Minor, primary residency $\ \square$ B	oth Parents □ Mom □ Dad □ Step	Parent $\ \square$ Shared Custody $\ \square$ Guardian	
Address: (if different from patient) Street	City	State Zip	
Phone: Home	Work	Mobile	
Employer (if different from above)	Occupation	Phone	
Address: Street	City	State Zip	
Dental Benefit Plan Informatio	n		
Primary Dental Plan Name		Phone	
Address: Street	City	State Zip	
Name of Insured	Date of Birth	ID Number	
Policy Number	Patient Relationship to Insure	ed	
Secondary Dental Plan Name		Phone	
Address: Street			
	City	State Zip	
Name of Insured	,	State Zip ID Number	

Medical Plan Information

Signature_

Plan Name		Phone	
	City		
Name of Insured	Date of Birth	ID Number	
Policy Number	Patient Relationship to Insured	Deductible Amount	
Whom may we thank for refe	erring you?		
□ One of our valued patients	(name of patient)		
□ Advertisement	□ Local Denta	Society	
□ Our Web site □ Other			
Please list other members of y	your immediate family who are patients in our practice		
	e committed to providing you with the best possible care and plain your financial and scheduling responsibilities with our pr		
completed in advance of perform	time services are rendered. Financial arrangements are discussing any treatment with our practice. We accept the following for third-party financing, administered through our practice, we a	g forms of payment	
	tal benefit is a contract between you or your employer and the act negotiated between you or your employer and the plan. We eir coverage.		
Our practice IS / IS NOT (circle	one) a contracted provider with your dental benefit plan.		
required to collect the patient's p	with your plan, you are responsible only for your portion of to portion (deductible, co-insurance, co-pay, or any amount not cortion is less than the amount determined by your plan, the a	covered by the dental benefit plan) in full at time of	
patients to receive reimbursemer providers, our practice can file th circumstance, you are responsible even if that amount is different to	ider with your dental benefit plan, it is the patient's responsibilition for services from out-of-network providers. If your plan allow the claim with your plan and receive reimbursement directly from a will be billed for any unpaid balance for services render than our estimated patient portion of the bill. If you choose to eimbursement directly from your dental benefit plan and will be a support of the bill.	ws reimbursement for services from out-of-network om the plan if you "assign benefits" to us. In this red upon receipt of payment from the plan to our practice, o not "assign benefits" to our practice, you are responsible	
time. Because of this courtesy, w utmost service and care, we do r to reserve the appointment time	We reserve the doctor and hygienist's time on the schedule for then a patient cancels an appointment, it impacts the overall equire 48-hour notice to reschedule an appointment. With lest again, may be required. To serve all of our patients in a timel or more arriving to our practice. To reschedule an appointment gain, may be required.	quality of service we are able to provide. To maintain the ss than 48-hour notice, a fee of \$ or deposit y manner, we may need to reschedule an appointment if	
	nat the information I have given today is correct to the best of at I may need and have consented to during diagnosis and tre		
I have read the above and agree	to the financial and scheduling terms (initial)		
I authorize the release of information me. YES / NO (Circle One)_	ation necessary to process my dental benefit claims. I hereby a (initial)	authorize payment directly to this doctor otherwise payable	
	y of this practice's Notice of Privacy Practices has been made ing this Notice (initial)	available to me. I have been given the opportunity to ask	
	y of this practice's Dental Materials Fact Sheet has been made ing this Fact Sheet(initial)	e available to me. I have been given the opportunity to ask	

__ Date __