

Patient Information:

Date: _____

Name _____ Birthdate _____ SSN _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Circle One: Married Single Minor **Circle One:** Male Female

Place of Employment: _____ If Student, School Name: _____

Family Information: Please fill in both blocks for minor child. Fill in appropriate block for adult.

<p>Circle One: Husband or Father</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20%;">Name</td><td></td></tr> <tr><td>Street Address</td><td></td></tr> <tr><td>City, State, Zip</td><td></td></tr> <tr><td>Home Phone</td><td></td></tr> <tr><td>Work Phone</td><td></td></tr> <tr><td>Cell Phone</td><td></td></tr> <tr><td>Date of Birth</td><td></td></tr> <tr><td>SSN</td><td></td></tr> <tr><td>Employer</td><td></td></tr> <tr><td>Insurance Co.</td><td></td></tr> <tr><td>Subscriber ID #</td><td></td></tr> <tr><td>Group #</td><td></td></tr> </table>	Name		Street Address		City, State, Zip		Home Phone		Work Phone		Cell Phone		Date of Birth		SSN		Employer		Insurance Co.		Subscriber ID #		Group #		<p>Circle One: Wife or Mother</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20%;">Name</td><td></td></tr> <tr><td>Street Address</td><td></td></tr> <tr><td>City, State, Zip</td><td></td></tr> <tr><td>Home Phone</td><td></td></tr> <tr><td>Work Phone</td><td></td></tr> <tr><td>Cell Phone</td><td></td></tr> <tr><td>Date of Birth</td><td></td></tr> <tr><td>SSN</td><td></td></tr> <tr><td>Employer</td><td></td></tr> <tr><td>Insurance Co.</td><td></td></tr> <tr><td>Subscriber ID #</td><td></td></tr> <tr><td>Group #</td><td></td></tr> </table>	Name		Street Address		City, State, Zip		Home Phone		Work Phone		Cell Phone		Date of Birth		SSN		Employer		Insurance Co.		Subscriber ID #		Group #	
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<p>Person to Contact in Case of Emergency</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20%;">Name</td><td></td></tr> <tr><td>Street Address</td><td></td></tr> <tr><td>City, State, Zip</td><td></td></tr> <tr><td>Phone #</td><td></td></tr> </table>	Name		Street Address		City, State, Zip		Phone #		<p>Has any member of your family ever been treated in our office? Circle One: Yes or No</p> <p>Who may we thank for referring you to Dental Solutions?</p> <hr/>
Name									
Street Address									
City, State, Zip									
Phone #									
<p>Authorization: I hereby authorize payment directly to Dental Solutions of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dental Solutions to administer such medications and perform such diagnostic, photographic, radiographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.</p> <p>_____</p> <p>Patient Signature or Signature of Responsible Party</p> <p>Date _____</p>	<p>Method of Payment:</p> <p>_____ Payment in full at each appointment</p> <p>_____ I wish to discuss the Dental Office's Financial Policy</p> <hr/> <p>Service Charge:</p> <p>If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$3.00 for a balance under \$200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.</p>								