

ACCOUNT INFORMATION - Person responsible for account or insurance policy holder -

Is anyone in your family who is already a patient in our practice? _____

Name: _____ Nickname: _____ Home Phone: _____

Street Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Employer: _____ Full time: ___ Part time: ___ SS#: _____

Employer Street Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Insurance Company: _____ Birth date: _____

Group Number: _____ Sex: M F

Please allow us to copy your insurance card Marital Status: _____

Other Information: (single, married, divorced, widowed)

Fax: _____ Beeper: _____ Email: _____

Spouse Name: _____ Employer: _____ Work Phone: _____

Employer: _____ Cell Phone: _____

Employer address: _____ City: _____ State: ___ Zip: ___ SS#: _____

Insurance Company (if applicable): _____ Birth Date: _____

Group Number: _____ Sex: M F

Please allow us to copy your insurance card

PATIENT INFORMATION - if different than account above -

Name: _____ Nickname: _____ Home Phone: _____

Street Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Sex: _____ Marital Status: _____ SS#: _____

Birth date: _____

Insured through which family member: _____

Relationship to policyholder: _____ (child, spouse)

Whom may we thank for your referral? _____

PAYMENT OPTIONS:

For your convenience we have the following payment options, please check one:

____ Prepay - 5% bookkeeping courtesy with cash or check only.

____ Cash, Check, Master Card or Visa at the time of treatment.

____ Payments through Dental Fee Plan or Care Credit (for balances over \$300)