# New Patient Information

## Patient Information

Date

09/06/2023

Patient's Last Name *

Patient's First Name *

MI

_

○ Married ○ Single ○ Minor

○ Male ○ Female

Social Security #

___-__-____

Birth Date *

MM/dd/yyyy

Address *

Street

Apt #

City *

State *

__

Zip Code *

_____

Home Phone

(___) ___-____

Work Phone

(___) ___-____

Cell Phone

(___) ___-____

Email

Name of Employer

Address

City

State

__

Zip Code

_____

If Full Time Student, School Name

Grade

Person Responsible for Account

○ Patient ○ Guardian ○ Spouse ○ Father ○ Mother

## Insurance Information

Minor Child - May need to complete both block for Parent Information
Adults - Complete Primary Insured
Dual Coverage? Also complete Secondary Insured

**Primary Insured**
If no Insurance, Complete for Responsible Party

Last Name

First Name

MI

_

Address

Street

City

State

__

Zip Code

_____

Home Phone

(___) ___-____

Work Phone

(___) ___-____

Cell Phone

(___) ___-____

Email

Birth Date

MM/dd/yyyy

Relationship To Patient

Employer

Dental Insurance Company

Social Security #

___-__-____

Subscriber #

Group #

**Secondary Insured**

Last Name

First Name

MI

_

Address

Street

City

State

__

Zip Code

_____

Home Phone

(___) ___-____

Work Phone

(___) ___-____

Cell Phone

(___) ___-____

Email

Birth Date

MM/dd/yyyy

Relationship To Patient

Employer

Dental Insurance Company

Social Security #

___-__-____

Subscriber #

Group #

**Person to Contact In Case of Emergency**

Name

Address

City

State

__

Zip Code

_____

Telephone #

(___) ___-____

Has any member of your family ever been treated in our office?

○ Yes ○ No

Whom may we thank for referring you to our office?

## Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic 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 gran 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 by any method, including electronic transfer.

Patient or Responsible Party *

Date

09/06/2023

Drivers License #

State

## Method of Payment

Responsible Party currently has an account with this office?

○ Yes ○ No

☐ Payment in full at each appointment

☐ I wish to discuss the Dental Office's Financial Policy

## Service Charge

If I do not pay the entire new balance within

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

% per month

or a minimum charge of

$

for the balance under

$

which is an annual percentage rate of

%

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.

Patient or Responsible Party *

Date

09/06/2023