GENERAL INFORMATION (please print)

Patient Name____ Home Phone_____________

Home Address____
Street city state zip

Birthday______________ Age_____ Sex M__ F__ Social Security #__________________ Driver Lic. #_______________

Occupation____________________ Employer________________________________ Business Phone_______________

Business Adress____
Street city state zip

Spouse's Name____ Employer_____________________

Business Address____Business Phone_________________

Whom may we thank for referring you to our office? ____

If patient is a minor (less than 18 years of age) give names of either parents or legal guardians:

Name______________________ relationship_______________________address__________________________

Name______________________relationship_______________________address__________________________

Nearest relative not living with you____Phone______________________

Name of your Physician (M.D.) ___________________________________ City____________________ last seen_________

Name of your former Dentist____________________________________ City____________________ last seen__________

INSURANCE INFORMATION (please fill in if you have coverage)

Dental Insurance Co.____ Local Union No.____________________

Group No.____

Spouse's Dental Insurance Co.____ Group No.__________________

Spouse's Social Security #____________________________________ Local Union No.____________________

FINANCIAL INFORMATION

1. Payment must be made for professional services as they are rendered. A finance charge of 1 ½ % (APR of 18%) will be added for unpaid balance over 30 days.
2. Finance arrangement preferred CASH____ CHECK_____ CREDIT CARD_____
3. Patient with DENTAL INSURANCE:

   If you direct the insurance company to pay their share of the cost directly to this office (this is called Assigning the Benefits) we will give you credit for this anticipated amount. Your insurance company will not be billed for services rendered until treatment has been completed. Often these payments are not received until two or three months, after being submitted for payment. Therefore, we do ask that you pay your estimated share of your treatment as it is rendered. However, you are still responsible for the total charges until we receive payment from your carrier. Please realize that professional services are rendered to a person, and not to the insurance company.

   Assignment of Benefits: I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.

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Signature of Insured Date

CONSENT:

Permission is granted to the dentist and staff of his employ to perform procedures, including the giving of anesthetics or photographs which may be necessary for my treatment or for purposes of dental and medical consultation and dental education. The undersigned hereby have read and understand the above financial information and take the financial responsibility of the patient above. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. I understand that X-ray films and other diagnostic aids remain the property of the dentist and may not be released to the patient or to other dentists.

__________________________ ____
Date Signature of Patient, Parent or Guardian