Today's Date____

Patient Information Form

Patient Name: First	MI Last	Nickname
Address: Street	City	StateZip
Phone: Home	Work	Mobile
E-mail address		
By Providing your e-mail address you agree t	o receive (check one or both) 🗆 Appoi	ntment Reminders
What is your preferred method of contact?	☐ Home Phone ☐ Work Phone ☐ M	obile Phone 🗆 E-Mail
Social Security Number		
Drivers License #	State	
Patient Employed By	Occupation	Phone
Address: Street	City	State Zip
Sex □ Male □ Female	•	·
In case of emergency, who should be notified	· ·	·
		Mobile Phone
Reidilonsinp to Fulletin	Home Thone	Mobile i Holle
Is the patient a Minor? □ Yes □ No Ful	l-time Student □ Yes □ No Name	of School
•		Last
		□ Parent □ Other
If patient is a Minor, primary residency \Box Bo		
	·	StateZip
	·	Mobile
		Phone
	•	State Zip
Dental Benefit Plan Information	1	
Primary Dental Plan Name		Phone
		State Zip
	•	ID Number
		eded
•	•	
Secondary Dental Plan Name		
	,	State Zip
Name of Insured	Date of Birth	ID Number
Policy Number	Patient Relationship to Insured	

Medical Plan Information

Signature_

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

__ Date __