ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, if insurance does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization

PATIENT (please fill out *ALL* fields)

PATIENT LAST NAME FIRST MIDDLE PREFERRED NAME TO BE CALLED TODAY'S DATE ☐ MALE ☐ FEMALE

BIRTH DATE M. D YR SOCIAL SECURITY NUMBER HOME PHONE ☐ NONE MESSAGE PHONE MARITAL STATUS ☐S ☐M ☐W ☐D ☐

MAILING ADDRESS CELL PHONE CITY STATE ZIP COD

E-MAIL ADDRESS BEST TIME OF DAY TO CALL May we contact you by email YES NO May we contact y by text messag YES NO

EMPLOYER ☐SELF ☐NONE ☐RET BUS. PHONE OCCUPATION DRIVER'S LICENSE NUMBER

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU RELATIONSHIP PHONE ( ) ADDRESS

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? RELATION

(PLEASE FILL OUT COMPLETELY) FINANCIAL RESPONSIBILITY

PERSON RESPONSIBLE LAST NAME FIRST MIDDLE RELATIONSHIP

HOME PHONE ☐SAME SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER ST

HOME ADDRESS ☐SAME AS ABOVE CITY STATE ZIP COD

EMPLOYER ☐SELF ☐NONE ☐RET BUSINESS ADDRESS BUS. PHONE OCCUPATION

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT ☐YES ☐NO SCHOOL ATTENDING CITY GRADE

PRIMARY DENTAL INSURANCE ☐NONE

INSURANCE CO. SUBSCRIBER'S LAST NAME FIRST MIDDLE SUBSCRIBER'S BIRTH DA

POLICY OR SOC. SEC. NO. GROUP NO. GROUP NAME RELATIONSHIP OF PATIENT TO SUBSCRI ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

SECONDARY DENTAL INSURANCE ☐NONE

INSURANCE CO. SUBSCRIBER'S LAST NAME FIRST MIDDLE SUBSCRIBER'S BIRTH DA

POLICY OR SOC. SEC. NO. GROUP NO. GROUP NAME RELATIONSHIP OF PATIENT TO SUBSCRI ☐SELF ☐SPOUSE ☐CHILD ☐OTHER