Today's Date\_

## **Patient Information Form**

atient Name: First	MI Last	Nickname	
ddress: Street	City	State Zip	
one: Home	Work	Mobile	
mail address			
Providing your e-mail address you agree to	receive (check one or both)   Appoi	intment Reminders □ Practice Newsletter	
hat is your preferred method of contact?	Home Phone □ Work Phone □ M	obile Phone 🗆 E-Mail	
cial Security Number	Date of Birth		
ivers License #		State	
itient Employed By	Occupation	Phone	
dress: Street	City	State Zip	
x □ Male □ Female	☐ Married ☐ Single ☐ Divorced ☐	Separated D Widowed	
case of emergency, who should be notified:	?		
lationship to Patient	Home Phone	Mobile Phone	
ne patient a Minor? 🗆 Yes 🗆 No 🔻 Full	-time Student □ Yes □ No Name	of School	
me of Responsible Party: First	Last		
e of Birth Relatio	onship to Patient 🗆 Self 🗆 Spouse	□ Parent □ Other	
atient is a Minor, primary residency □ Bo	th Parents □ Mom □ Dad □ Step	Parent □ Shared Custody □ Guardian	
dress: (if different from patient) Street	City	State Zip	
one: Home	Work	Mobile	
ployer (if different from above)	Occupation	Phone	
dress: Street	City	State Zip	
ental Benefit Plan Information	1		
mary Dental Plan Name		Phone	
dress: Street	City	State Zip	
me of Insured	Date of Birth	ID Number	
icy Number	Patient Relationship to Insur	ed	
ondary Dental Plan Name		Phone	
dress: Street		<b>3</b>	
	City	State Zip	
me of Insured	·	StateZipZip	

## **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		ard
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 ar	overed 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 pra- not "assign benefits" to our practice, you are response	ictice, isible
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 maintair s than 48-hour notice, a fee of \$ or der y manner, we may need to reschedule an appointmen	n the posit nt 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		rm
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 pa	ayabl
	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	:o ask
	of this practice's Dental Materials Fact Sheet has been made ng this Fact Sheet (initial)	available to me. I have been given the opportunity	to asl

\_\_ Date \_\_