PATIENT FINANCIAL INFORMATION

Soc. Sec. #: _____
Cell Phone _____
Name_____ Birthdate_____ Home/Phone_____

Address_____ City_____ State_____ Zip_____

REFERRING DENTIST_____ GENERAL DENTIST_____

Patient Employer _____ Work Phone _____

Business Address_____ City_____ State_____ Zip _____

Dental Insurance Primary _____ Secondary Ins._____

Patient's Spouse _____ Spouse's Employer _____

Spouse's Business Address _____ City _____ State _____ Zip _____

Person to Contact in Case of Emergency? _____ Phone _____

Today's method of payment Credit Card Check Other _____

FOR MINORS ONLY: RESPONSIBLE PARTY (Parents signing for minor may NOT designate spouse)

Person responsible for payment of this account: _____

Relationship to patient? _____ Has responsible party been a patient in our office? _____

Responsible party: Address _____

Home Phone: _____ Birthdate _____ SS# _____

Employer: _____ Address _____

Work Phone: _____ Insurance Yes_____ No _____

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and /or other health practitioners.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependent.

Payment is due at time of treatment unless other arrangements are made in advance. If it becomes necessary to use collection procedures due to non-payment, any and all additional fees, including but not limited to attorney, court and collection agency fees incurred by this office, will also be my responsibility.

x _____ **x** _____
Signature of patient (or parent/ guardian if minor) **Date**

I authorize and request my insurance company to pay direct to the dentist insurance benefits otherwise payable to me

x _____ **x**_____
Signature of patient (or parent/guardian if minor) **Date**