

NEW PATIENT INFORMATION FORM

Name _____ Date of Birth _____
Preferred Name _____ Martial Status _____
Address _____
Phone Numbers: H _____ W _____ C _____
Email Address _____ Gender: Male _____ Female _____
Social Security # _____ Referred By _____
Employer _____ Address _____
Emergency Contact _____

If under 18 years of age, person responsible for account:

Name _____ Home# _____ Work# _____
Address _____
Social Security # _____ Relationship to Patient _____

INSURANCE INFORMATION

Primary

Subscriber Name _____ Date of Birth _____
Insurance Company _____ Employer _____
Phone # of Ins. Co _____ ID # _____ Group # _____
Social Security # _____

Secondary

Subscriber Name _____ Date of Birth _____
Insurance Company _____ Employer _____
Phone # of Ins. Co _____ ID # _____ Group # _____
Social Security # _____

FINANCIAL INFORMATION

We will be happy to file any dental insurance, however; it is the patient's responsibility for any balances not paid by their insurance. If insurance information is not given, payment for services is due at the time services are rendered. Accepted payment methods are Visa, Master Card, Discover, cash and check. Any unpaid account balance over 30 days is subject to a 1.5% per month finance charge. Any unpaid balance over 90 days is subject to be turned over to a collection agent along with a 35% collection fee, and \$10 postage fee. If legal action is required on an account a \$50 fee will apply.

By signing this form I give my authorization to furnish the required information to my insurance company and assign benefits to this office. I hereby certify that all of the above information is true and correct to the best of my knowledge and agree to accept financial responsibility for any balances due on my account.

Signature: _____ Date _____

PRIVACY DISCLOSURE

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. I have been offered or received a copy of this office's Notice of Privacy Practices and have been given full opportunity to read and considered the contents. I also understand that your office will not be able to file any insurance claims unless this consent is signed.

Signature: _____ Date _____