

Patient Acct # \_\_\_\_\_

Responsible Party Acct # \_\_\_\_\_

Patient's Full Name \_\_\_\_\_

Patient's street address: \_\_\_\_\_

Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

S.S.I # \_\_\_\_\_ Date of birth \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Ext. \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer's name: \_\_\_\_\_

Street address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_

Complete address: \_\_\_\_\_

Has any other member in your family been seen here? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency? \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Do you have dental insurance: yes \_\_\_\_\_ No \_\_\_\_\_

Primary Coverage: Insured employee's name \_\_\_\_\_

SSI # \_\_\_\_\_

Insurance Co. name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Local # \_\_\_\_\_ Phone # \_\_\_\_\_

Assignment of benefits: I hereby state that I am financially responsible for my account and I authorize my insurance benefits (if any) to be paid directly to the Dentist. I also authorize the dentist to release any requested information to my insurance company.

I understand that if my account should be referred to an attorney or collection agency for collections, that I will be responsible for the collection cost in the amount not to exceed 35% of the balance due plus court cost.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date