Personal Information

Patient's Name: ______________________ **Preferred Name:** ______________ **Date:** ______________

Parent/Guardian (If Minor): ______________________ **Social Security #:** ____________ **Date of Birth:** ____________

Spouse Name: ______________________ **Social Security #** ______________ **Gender:** __ **Male** __ **Female**

Street Address: ______________________ **City:** ______________ **State:** _____ **Zip Code:** __________

Telephone Number: (Home) ______________ **(Cell)** ______________ **(Work)** ______________

Email Address: ______________________________ **Referred By:** ______________________

Emergency Contact Person: ______________________ **Telephone #** __________ **Relationship:** ______________

Insurance Information

Name of Employer: ______________________ **Address:** ______________________________

Name of Dental Insurance Co.: ______________________ **Group Number:** __________ **Subscriber ID#:** __________

Spouse's Employer: ______________________ **Work #** __________ **Cell #** __________

Spouse's Dental Insurance Co. ______________________ **Group Number:** __________ **Subscriber ID #** __________

Method of Payment

Payment is expected at time of service.

We accept __ Cash __ Check __ Credit Card (MasterCard, Visa, and Discover Card)
For larger balances we also have third party financing with Wells Fargo Financial.

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COST OF DENTAL TREATMENT.** I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

I understand for my convenience you will bill my insurance company directly for estimated covered services. **Ultimately, however, I understand that I am responsible for any and all fees not paid by my insurance company within 30 days of being billed.**

I have read and understand this authorization.

Patient Signature: ______________________________________ **Date:** ______________