CONFIDENTIAL

PERSONAL HISTORY

PLEASE PRINT DATE: _______________

Patient Name: ______________________________ Date of Birth: ______________ Gender:_____________

Address: ___________________________________ City: _______________________ St: ___ Zip: _________

Home Number: _____________________ Work: _____________________ Cell: _______________________

Email: ____

How would you like to be contacted? ☐ Email ☐ Cell ☐ Home ☐ Work

Social Security Number: ____________________________ S.S.N. of Policy Holder: _____________________

Name of Policy Holder: ____________________________ D.O.B. of Policy Holder: ____________________

Employer of Policy Holder: ____

Dental Insurance Carrier: ____

Who can we thank for referring you to this office? ____

Financial Responsibility Statement

I accept financial responsibility for treatment performed by this office. I understand only primary insurance forms will be completed at no extra charge, and secondary claims must be filed by the subscriber. Any balance not covered by the insurance carrier is my responsibility. Our office does not participate with any HMO or DMO insurance carriers. I agree if my account is referred to collection I will pay, in addition to the original amount owed, all costs of collection, including attorney's fees equal to the 1/3 of the debt owed. After 90 days the unpaid balance is subject to a monthly service charge of 1.50%. **Because all appointments are confirmed, a fee of $75.00 may be charged for appointments** cancelled without 24-hour notice.

_____________________________________ _____________________________________

Patient Signature

Parental Permission
(if patient is under 21)