Personal Information

Last Name	First Name	M.I.	Preferred Name

Street Address	City	State	Zip Code

Social Security #	Home Phone	Work Phone	Cell Phone

Marital Status __Single __Married __Widowed __Separated __Divorced	Sex M/F	Birthday

Email Address: ____

Do you prefer Email or Text Reminders/Notifications? ___________________________

Employment Information

Employer	__Full time __Part time __Retired __Not employed		How Long?	Occupation
Employer Address	**City**	**State**	**Zip Code**	

Spouse Information

Last Name	First Name	M.I.	Birthdate

Employer	How Long?	Work Phone	Social Security #

Employer Address	City	State	Zip Code

Payment Information

Person Responsible for Account Name: ______________________ **SSN:** ______________________ **Birthday:**	Address (if different than self)	Employer
Dental Insurance –Primary __ Yes __No	Insurance Co. Carried by: __Self __ Spouse __ Parent Member ID # ____________________ Group# ________________________	Phone Number
Dental Insurance -Secondary __Yes __No	Insurance Co. Carried by: __Self __ Spouse __ Parent Member ID # ____________________ Group # ________________________	Phone Number

Referral Source:

Phone Book_______Church Bulletin ______ Internet _______ Facebook _______ Angie's List _______Website_______

Referred by: ____________________________________ Other: __________________________________

Contact: Please list someone (other than spouse) for us to contact in case of emergency.

Name: ____________________________ Relationship: _______________ Phone: ____________________

OVER→

Financial Policy For Our Patients

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 authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

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 on my behalf or on behalf of my dependents.

I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balance.

___________________________ ______________
Signature Date

Our office wants all our patients to be able to comfortably afford dental care. We proudly offer the following financial policy so that our patients can have the opportunity to decide which payment option best suits your needs:

Insurance: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Because of this, you will be asked to pay your deductible and your co-payment for charges on the day the service is rendered. We will estimate as closely as possible your coverage, **but we can make no guarantee of any estimated coverage.** Because the insurance policy is an agreement between you and your insurance company, the ultimate responsibility for all charges lies with you. If after 60 days the insurance company has not paid on the claim, you will be responsible for the total balance.

Payment Options:

1. **Cash or Check.**
2. **Credit Card.** Our office accepts VISA, MasterCard, Discover, and American Express
3. **Outside Financing.** CareCredit is a credit card with an outside financing company that can be applied for through our office. The application is called in from our office or online we usually know within minutes if the applicant is approved. This is a 3,6,12 or 18 month deferred interest card with payments being made directly to CareCredit.