



Welcome to our Practice!!

Patient Information (Confidential)

Name _____ Date: _____
 Address _____ City _____ State _____ Zip/P.C. _____
 E-mail _____ Cell Phone _____ Home Phone _____
 SS#/SIN _____ Birthdate _____

Do you prefer to receive calls at your: Home Work Cell

Check Appropriate Box Minor Single Married Divorced Widowed Separated

If student, Name of School _____ City _____ State _____ F.T P.T.
 Patient or Parent/Guardian's Employer _____ Work Phone _____
 Business Address _____ City _____ State _____ Zip _____
 Spouse or Parent's/Guardian's Name _____ Employer _____ Work Phone _____
 Person to contact in case of Emergency _____ Phone _____
 Whom may we thank for Referring you? _____

Responsible Party

Person Responsible for this Account _____ Relationship to Patient _____ Same as above
 Address _____ City _____ State _____ Zip/P.C. _____
 E-mail Address _____ Cell _____
 Employer _____ Work _____
 Phone _____
 Driver's License# _____ Birthdate _____ SS#/SIN _____

Is this person currently a patient in our office: Yes No
 For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card Care Credit I wish to discuss the office's payment policy

Insurance Information

Name of the Insured _____ Relationship to Patient _____
 Birthdate _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Address of Employer _____ City _____ State/Prov. _____ Zip Code _____
 Insurance Company _____ Group # _____ Policy/ID# _____
 Ins. Co. Address _____ City _____ State//Prov _____ Zip Code _____
 How much is your Deductible? _____ How Much have you used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURNACE?? Yes No

Name of the Insured _____ Relationship to Patient _____
 Birthdate _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Address of Employer _____ City _____ State/Prov. _____ Zip Code _____
 Insurance Company _____ Group # _____ Policy/ID# _____
 Ins. Co. Address _____ City _____ State//Prov _____ Zip Code _____
 How much is your Deductible? _____ How Much have you used? _____ Max. Annual Benefit _____

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.

This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Center for Cosmetic Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand the information that I have given today is corrector the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility be to inform this office of any changes in my medicate status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____
Signature of patient (or parents/guardian if minor) _____ Date _____