CONFIDENTIAL PATIENT INFORMATION

GET ACQUAINTED QUESTIONNAIRE

Welcome to our office. We feel you will be pleased with the care you will be receiving. In order to begin treatment, the following information is necessary. Please complete fully and PRINT legibly. All information, of course, will be held in strict confidence. Thank you for joining our family of patients. Account # _____

PATIENT HISTORY INFORMATION

PATIENT'S NAME _____ HOME PHONE _____
SOC. SEC. # _____ BIRTHDATE _____ AGE _____ SEX _____ MARITAL STATUS _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PATIENT'S EMPLOYER _____ WORK PHONE _____
SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____
PERSON TO NOTIFY IN CASE OF EMERGENCY _____ PHONE _____
RELATIVE OR FRIEND NOT LIVING WITH YOU _____ PHONE _____
STUDENT: ❑ FULL TIME ❑ PART TIME SCHOOL _____ CITY _____

FAMILY MEMBERS:		AGE	LAST VISIT TO THE DENTIST
SPOUSE			
CHILD			
CHILD			
CHILD			
CHILD			

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____
RELATIONSHIP TO PATIENT _____ HOME PHONE _____ WORK PHONE _____
MAILING ADDRESS _____ CITY _____ ZIP _____
SOC. SEC # _____ DRIVER'S LICENSE # _____
EMPLOYER _____ OCCUPATION _____
EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____

DENTAL INSURANCE ❑ YES ❑ NO
INSURED'S NAME _____
SS # _____ BIRTHDAY _____
EMPLOYER _____
INS. CO. OR PLAN _____
UNION/GRP. NAME _____
GRP. OR POLICY # _____ LOCAL # _____
DATE EMPLOYED _____

SECONDARY INSURANCE ❑ YES ❑ NO
INSURED'S NAME _____
SS # _____ BIRTHDAY _____
EMPLOYER _____
INS. CO. OR PLAN _____
UNION/GRP. NAME _____
GRP. OR POLICY # _____ LOCAL # _____
DATE EMPLOYED _____

HOW DID YOU HEAR ABOUT THIS OFFICE? ❑ FORMER PATIENT WHO? _____
❑ UNION ❑ TELEPHONE BOOK ❑ SAW BLDG./SIGN ❑ EMPLOYER
❑ ADVERTISEMENT WHICH? _____ ❑ OTHER _____
WHY ARE YOU HERE TODAY? ❑ CHECK-UP ❑ TOOTHACHE ❑ BRACES ❑ CAPS ❑ IMPROVE SMILE
❑ OTHER _____

CONSENT AND FINANCIAL RESPONSIBILITY

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my Insurance Carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. I understand if my insurance company does not pay in full, I am responsible for the remaining balance. I understand some dental services I receive may require a co-payment from me. The amount of the co-payment will vary according to the insurance/dental plan I have and the procedure that is performed. If my insurance/dental plan has a yearly deductible, I understand it must be satisfied before treatment begins. I also understand co-payments must be paid in full at the time of treatment. A finance charge of 1.5% per month (18% per annum) will be charged on the unpaid principal balance on all accounts not paid within 30 days of the date of service.

I further understand dental services not covered by my insurance/dental plan may be prescribed in certain cases by the attending dentists. Usual, customary and reasonable fees will be charged for such services.

I also understand there will be a charge for any missed appointment which is not canceled 24 hours in advance.

_____ _____
Patient Signature Date

_____ _____
Responsible Party Signature Date