Patient Name_____ Soc. Sec. No._____

Marital Status Single Married Divorced Widowed

Address_____ Birthdate_____

City/State/Zip_____ Home Ph#_____

Employer_____ Work Ph#_____

Email address _____ Cell Ph#_____

How did you obtain our number? _____

Primary Dental Insurance Information

Employee Name_____ Soc. Sec. No._____

Relationship to patient_____ Employee Birthdate _____

Employer_____ Employer's Ph # _____

Dental Ins Company _____ Group # _____

Dental Ins I.D. # _____ Ins Ph # _____

Secondary Dental Insurance Information

Employee Name_____ Soc. Sec. No._____

Relationship to patient_____ Employee Birthdate _____

Employer_____ Employer's Ph # _____

Dental Ins Company & Ph# _____ Group # _____

Dental Ins I.D. # _____

Responsible Party Please Check One:

_____ Patient will pay in full each visit (Cash, Check or Major Credit Card)

_____ Patient has Dental Ins and will pay patient portion at each visit.

I understand that I am ultimately responsible for FULL PAYMENT OF ALL CHARGES regardless of any insurance coverage. Should I default in this obligation, the creditors may without notice take such steps as are provided by law to secure the unpaid balance of my account and any attorney's fees, court costs and/or collection expenses.

Please sign & date _____