TOTAL CARE DENTAL

PATIENT INFORMATION SHEET
DATE ____/____/____

Please complete all of the applicable information below. If you have any questions ask the receptionist.

Patient Information

Name: _____
Title First MI Last Nickname

Address: _____
Street City State Zip

Phone: (_____)_____-_____ (_____)_____-_____ _____ (_____)_____-_____
Home Work Ext. Cell

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Email Address: _____ Driver's License Number: _____
Who may we thank for referring you to us (How did you hear about us?) _____

Spouse's Name: _____ Closest Relative: _____
First MI Last First MI Last

Phone: (_____)_____-_____ _____

Billing Information

Name: _____
Title First MI Last Nickname

Address: _____
Street City State Zip

Phone: (_____)_____-_____ (_____)_____-_____ _____ (_____)_____-_____
Home Work Ext. Cell

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Email Address: _____ Driver's License Number: _____

Primary Dental Insurance Information

Insurance Company Name: _____

Group/Employer Name: _____

ID Number: _____Group Number: _____ Phone: (_____)_____-_____

Address: _____
Street City State Zip

Annual Coverage: _____ Deductible: _____

Insured Name: _____ Relationship: _____
First MI Last

Insured Date of Birth: _____/_____/_____ Insured Social Security Number: _____-_____-_____

Insured Address: _____
Street City State Zip

Employer Name: _____

Employer Address: _____
Street City State Zip

Secondary Dental Insurance Information

Insurance Company Name: _____

Group/Employer Name: _____

ID Number: _____Group Number: _____ Phone: (_____)_____-_____

Address: _____
Street City State Zip

Annual Coverage: _____ Deductible: _____

Insured Name: _____ Relationship: _____
First MI Last

Insured Date of Birth: _____/_____/_____ Insured Social Security Number: _____-_____-_____

Insured Address: _____
Street City State Zip

Employer Name: _____

Employer Address: _____
Street City State Zip

Payment Information

Payment is expected at the time of service for all emergencies and services. We accept major credit cards, cash or personal checks. Your cooperation is appreciated.

When the amount of service is over $1,000.00 we offer a 5% discount for payment in full when payment is made 1 week prior to the appointment.

We are affiliated with Care Credit, Lending Club and CitiHealth for those who desire extended payments. This requires an application and approval from the company. Using one of these, we can offer a 3, 6 or 12 month interest free payment period. Longer periods of time with a predetermined interest rate can be arranged with approval of the application.

Interest will be charged to your account from the purchase date at the APR for purchases 26.99% - 28.99% if the balance is not paid in full within the promotional period or you make a late payment or are otherwise in default*. *The Penalty Rate for this account is 29.995. Annual Fee: None. Minimum finance charge: $.50. See the Disclosures provided at time of transaction for more information about this promotion. Credit issued by Citibank (South Dakota), N.A.; GE Money Bank. Subject to credit approval. This offer is available only to applicants who reside in the U.S.

Please indicate which method of payment you prefer:

____ cash ____ personal check ____credit card ____Care Credit/CitiHealth/Lending Club

Consent Information

I have reviewed the information above and assert that it is accurate to the best of my knowledge. I understand that prior to treatment, the doctor and/or his/her staff will have or have explained the procedure(s) involved. I understand that I am financially responsible for all charges rendered, whether paid by an insurance carrier or not, and that balances over 90 days will be charged a monthly service fee for each month the balance is carried. In the case of default, I promise to pay any legal interest on balances due together with any collection costs and reasonable attorneys' fees incurred to effect collection of this account.

_____

Signature of Patient (or guardian if patient is a minor) **Date**

_____

Signature of Insured **Date**