TOTAL CARE DENTAL

PATIENT INFORMATION SHEET

DATE ____/____/____

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 or 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

Group/Employer Name: _____

Insurance Company Name: _____

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

Insured Name: _____ Relationship: _____
First MI Last

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

Insured Address: _____
Street City State Zip

Secondary Dental Insurance Information

Group/Employer Name: _____

Insurance Company Name: _____

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

Insured Name: _____ Relationship: _____
First MI Last

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

Insured 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 fee for service(s) is over $1,000.00 we offer a 5% adjustment for payment in full when paid 1 week prior to the appointment.

Special financing available*

***Subject to credit approval. Minimum monthly payments required. Ask us for details.**

Please indicate which method of payment you prefer:

____ cash ____ personal check ____credit card ____special financing*

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**