## **Patient Information**

Name:	MI		1		NII-I	
riue First	en de la companya de La companya de la companya de		Last		Nickname	
Address:					and the second second	Topy reputation
Street		City	and the transfer and	State	Zip	
Phone: (	()	<u> </u>		_(		
Home		Work	Ext.		Cell	
Date of Births /		Carial Carr				
Date of Birth:/		Social Secu	rity Number:	en en artist de la companya de la co		
E I A .I I						
Email Address:		Driver's Lic	ense Number:			
Who may we thank for referring	you or how did you h	ear about us?				
	you of flow ald you fi	car about us:		, . A 31		
Spouse's Name:		Closest Relati	ive:		en e	
First M	II Last		First	MI	Last	
		Phone: (	)		<u> </u>	
Billing Information						
Name						
Name:	MI		Last		Nickname	State of the
Address:		City		State	Zip	
					i jer e viza i e	
Phone: ()		 Work	Ext.	<u> </u>	Cell	<u> </u>
Date of Birth:/		Social Secu	rity Number:		1 - 11 - 121 - 121 - 12 - 12 - 12 - 12	r Bayera <u>Labera tab</u>
Email Address:		Driver's Lice	ense Number:			
				1.5		
Primary Dental Insurance	<u>Information</u>					
Group/Employer Name:						
Sioup/Employer Name.						
Insurance Company Name:						
			1,7			-
ID Number:	Group Number	•	Phone	: (	)	
Insured Name:			D-I	- <b>- :</b>   - :		
III ISUI CU INGIIIC.	MI Last		Kel	ationship:		
First	ivii Last	and the second of the second o				
		rad Casial Casi	, Number			
First Insured Date of Birth:/_		ed Social Security	/ Number:			

## **Secondary Dental Insurance Information** Group/Employer Name: Insurance Company Name: ID Number: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_-Insured Name: \_\_\_\_\_\_ \_\_\_\_\_\_ Relationship: Insured Date of Birth: \_\_\_\_/\_\_\_ Insured Social Security Number: \_\_\_\_ -Insured Address: State **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 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**