



FAMILY DENTISTRY

We are pleased to welcome to our practice!  
Please take a few minutes to fill out the forms **COMPLETELY**

**Patient Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_  
Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Please circle:    Single    Married    Other    Sex :    Male    Female  
Birth Date: \_\_\_\_\_ Social Security# (REQUIRED): \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone \_\_\_\_\_

**Responsible Party Information**

Name: \_\_\_\_\_  
Residences: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Social Security# (REQUIRED): \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

Insurance Company: \_\_\_\_\_  
Insurance Company address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber ID #: \_\_\_\_\_

Please ask for an additional form, if billing to a secondary insurance.

**Payment Responsibility**

**For our patients without dental insurance...**I understand that all responsibility for dental services provided in this office for myself or my dependants is mine, due and payable at the time of services are rendered.  
**For our patients with dental insurance.** I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately responsible for payment of all dental services provided in this office to myself or my dependants. My co-payment is due and payable at the time services are rendered. Any unpaid balances over 90days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claim to this office.  
If I become necessary to enlist a collection agency, the responsible party agrees to pay all cost to collection.  
I understand that it is my responsibility to advise your office of any changes to the information contained on this form.  
**IF you have any questions regarding your insurance please contact your insurance provider. We bill as a courtesy to your insurance.**

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_