PATIENT INFORMATION:

Date: _____

Patient's Name: _____ _____ _____ Nick-name: _____
First Middle Last

Patient's Address _____ _____ Marital Status: _____
House Number & Street P.O. Box

_____ _____ _____ ☐ Male ☐ Female
City State Zip Code

Date of Birth: _____ Social Security Number: _____

House Phone # _____ Work Phone # _____ Cell Phone # _____

Employer: _____

Emergency Contact: _____ Relationship: _____ Phone# _____

Are you covered by: ☐ Dental Insurance ☐ Medicaid ☐ Other: _____

If over age 18, are you in college? ☐ YES ☐ NO Name of College: _____

GUARANTOR INFORMATION:

Guarantor's Name: _____ _____ _____ Relation to Patient: _____
First M.I. Last

Patient's Address _____ _____
House Number & Street P.O. Box

_____ _____ _____
City State Zip Code

Date of Birth: _____ Social Security Number: _____

Home Phone # _____ Cell Phone # _____

Employer: _____ Work Phone # _____

AUTHORIZATION:

List the names and relationship of anyone with whom you give us permission to speak, regarding your account

_____ _____

_____ _____

I understand that I am responsible for the complete cost of dental treatment. I understand that I am responsible for any charges not covered or paid by insurance. I understand that an APR of 18% will be added to my account on any balance not paid in full within 30 days.

Signature: _____ Date: _____