Name _____
Male [ ] Female [ ] Age _____ Height _____ Weight _____ Marital Status _____
Address _____
City _____ State _____ Zip _____
Primary Phone # _____ Email _____
Student [ ] Employer _____ Work Phone # _____
Social Security # _____ Birth Date _____
Your Primary Physician _____

Emergency Contact _____ Relationship _____
Phone # _____

Guarantor Information for Patients Under the Age of 18

Name _____
Billing Address _____
City _____ State _____ Zip _____
Relationship to Patient _____
Social Security #_____ Birth Date _____
Home Phone _____ Work Phone _____
Employer _____

Financial and Insurance Policy

Payment is due in full today for all services. We will file your primary insurance for you when you provide us with the following information. All accounts over 90 days, regardless of insurance payment, are subject to collection by a collection bureau.

Primary Dental Insurance

Insurance Company Name _____
Policy Holder's Name _____ Social Security #_____
Relationship to Patient _____ Birth Date_____
Policy Holder's I.D. # _____ Group # _____
Employer _____

Primary Medical Insurance

Insurance Company Name _____
Policy Holder's Name _____ Social Security #_____
Relationship to Patient _____ Birth Date_____
Policy Holder's I.D. # _____ Group # _____
Employer _____

X_____ X _____
Signature of Patient (Parent or Guardian if minor) Date