# ***Patient Personal Information***

| | | | |
|---|---|---|---|
| **Patient's Name** | | **Male or Female** | |
| **Patient's Birth date** | | **Age** | |
| **Address** | **City** | **State** | **Zip** |
| **Home Phone Number:** | **Cell Phone Number:** | **Email Address:** | |
| **Who may we thank for referring you?** | | | |
| **_____(Please Initial) I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes.** | | | |

**Guardian Information**

| | | |
|---|---|---|
| **Name of parent/responsible guardian** | | **Relation to patient** |
| **Guardian birth date** | **Soc. Sec. #** | **Married/Single/Divorced** |
| **Employer** | **Occupation** | **Work phone number** |
| **Spouse Name** | | **Relation to patient** |
| **Spouse birth date** | **Soc. Sec. #** | |
| **Employer** | **Occupation** | **Work phone number** |
| **Emergency Contact Information: Please give the names of the two nearest relatives not living with you** | | |
| **Name** | **Relationship** | **Phone number** |
| **Name** | **Relationship** | **Phone number** |

**Insurance Information**

| | | |
|---|---|---|
| **Primary Dental Insurance** | | **Name of policy holder** |
| **ID Number** | **Group Number** | |
| **Secondary Dental Insurance** | | **Name of policy holder** |
| **ID Number** | **Group Number** | |

**Authorization**

**I am aware that if I no show to my scheduled appointment or give less than a 24 business hour notice I will be charged a $25 no show fee for every half hour I was scheduled.**
**I authorize routine diagnostic procedures. Insurance coverage is only an estimate. Guarantor is responsible for all treatment not covered by insurance. It is my responsibility to understand my insurance benefits. I also agree to pay my dental estimate, or in the case of no insurance coverage, all fees in full at the time of treatment. Should any balance remain after 90 days, I will pay interest at the annual rate of 21% (1.75% per month) starting from the date the charges were made.**
**Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 21% APR, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.**

**Signature: ________________________________________________________ Date: _______________**

**Please Print Name: _____________________________Relationship to patient ___________________**