PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE:   PATIENT   GUARDIAN   SPOUSE   FATHER   MOTHER    INSURANCE INFORMATION   MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION ADULTS - COMPLETE PRIMARY INSURED    PRIMARY INSURED / IF NO INSURANCE COMPLETE SECONDARY INSURED    PRIMARY INSURED / IF NO INSURANCE COMPLETE SECONDARY INSURED    STREET   CITY   STATE   ZIP    HOME   WORK   CELL   E-MAIL    BIRTHDATE (MODAVYEAR)   RELATIONSHIP TO PATIENT    EMPLOYER   DENTAL INS. CO    SS#   SUBSCRIBER#   GROUP#    SECONDARY INSURED    LAST   FIRST   M    EMPLOYER   CELL   E-MAIL    BIRTHDATE (MODAVYEAR)   RELATIONSHIP TO PATIENT    EMPLOYER   DENTAL INS. CO    SS#   SUBSCRIBER#   GROUP#    SS#   SUBSCRIBER#   GROUP#    Whom may we thank for referring you to our office?    WHOM may we thank for referring you to our office?    WETHOD OF PAYMENT    Responsible party currently has an account with this office    Yes   No    WHOM may we thank for referring you to our office?    WETHOD OF PAYMENT    Responsible party currently has an account with this office    Yes   No    Payment in full at each appointment (cash or personal check)    Payment in full at each appointment (cash or personal check)    Payment in full at each appointment (cash or personal check)    Payment in full at each appointment (cash or personal check)    Payment in full at each appointment (cash or personal check)    Payment in full at each appointment (cash or personal check)    Payment in full at each appointment (cash or personal check)    Payment in full at each appointment (cash or personal check)    Payment in full at each appointment (cash or personal check)    WETHOD OF PAYMENT    WETHOD OF PAYMENT    RELATIONSHIP TO PAYMENT    PRIMARY INSURED    BIRTHDATE (MODAVYEAR)    BIRTHDATE (MODAVYEAR)    RELATIONSHIP TO PAYMENT    PRIMARY INSURED    BIRTHDATE (MODAVYEAR)    BIRTHDATE (MODAVYEAR)    BIRTHDATE (MODAVYEAR)    BIRTHDATE (MODAVYEAR)    BIRTHDATE	PATIENT INFORMATION		DATE				
ADDRESS    STREET   APT.# OTY   STATE   ZP	NAME		r	M	_	INGLE MINOR MA	LE FEMALE
BIRTHDATE    MONTH   DAY   YEAR   TELEPHONE   MONTK   CEL   E-MAIL							
BIRTHDATE    MONTH   DAY   YEAR   TELEPHONE							
ADDRESS  IF FULL TIME STUDENT, SCHOOL NAME	ADDRESSst	rreet A	APT. #	CITY	S	TATE	ZIP
ADDRESS  IF FULL TIME STUDENT, SCHOOL NAME	BIRTHDATE	TELI	EPHONE				
PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE:   PATIENT   GUARDIAN   SPOUSE   FATHER   MOTHER   MOTHER   MOUNT   MOUNT   COMPLETE BOTH BLOCKS FOR PARENT INFORMATION   ADULTS - COMPLETE PRIMARY INSURED   ADULTS - COMPLETE BOTH BLOCKS FOR PARENT INFORMATION   ADULTS - COMPLETE PRIMARY INSURED   SECONDARY INSURED							
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PRIMARY INSURED   FOR RESPONSIBLE PARTY	PERSON RESPONSIBLE FOR	ACCOUNT - PLEASE	CHECK ONE	: PATIENT	GUARDIAN [	SPOUSE FATHER [	MOTHER
PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY  LAST FIRST M  STREET CITY STATE ZIP  HOME WORK CELL E-MAIL  BIRTHDATE (MOIDAY/YEAR) RELATIONSHIP TO PATIENT  EMPLOYER DENTAL INS. CO  SS# SUBSCRIBER# GROUP#  PERSON TO CONTACT IN CASE OF EMERGENCY  Name	INSURANCE INFORMATION	ADULTS - COMPL	ETE PRIMARY INSU	JRED		FORMATION	
LAST FIRST M  STREET CITY STATE ZIP  HOME WORK CELL E-MAIL  BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT  EMPLOYER DENTAL INS. CO  SS# SUBSCRIBER # GROUP #  PERSON TO CONTACT IN CASE OF EMERGENCY  Name  Address  City/State/ZIP  Telephone #  AUTHORIZATION  I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office's Financial Policy  Wish to discuss the Dental Office's Financial Policy  Wish to discuss the Dental Office's Financial Policy		DUAL COVERAGE	E? ALSO COMPLETI	SECONDARY	INSURED		
STREET CITY STATE ZIP  HOME WORK CELL E-MAIL  BIRTHDATE (MO/DAY/YEAR) RELATIONSHIPTO PATIENT  EMPLOYER DENTAL INS. CO  SS# SUBSCRIBER# GROUP#  PERSON TO CONTACT IN CASE OF EMERGENCY  Name  Address  City/State/ZIP  Telephone #  AUTHORIZATION  I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental  I wish to discuss the Dental Office's Financial Policy	PRIMARY INSURED / IF NO FOR F	INSURANCE COMPLETE RESPONSIBLE PARTY	<u> </u>	SECON	DARY INSURED		
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BIRTHDATE (MO/DAY/YEAR)  RELATIONSHIPTO PATIENT  EMPLOYER  DENTAL INS. CO  SS#  SUBSCRIBER #  GROUP #  Has any member of your family ever been treated in our office?  Yes No  Whom may we thank for referring you to our office?  WETHOD OF PAYMENT  Responsible party currently has an account with this office  Yes No  WETHOD OF PAYMENT  Responsible party currently has an account with this office  Yes No  Payment in full at each appointment (cash or personal check)  Payment in full at each appointment (UVISA MC OTHER Card # Exp. Date Exp. Date In wish to discuss the Dental Office's Financial Policy	STREET CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
PERSON TO CONTACT IN CASE OF EMERGENCY  Name  Address  City/State/ZIP Telephone #  AUTHORIZATION  I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office's Financial Policy  EMPLOYER  DENTAL INS. CO  SS#  SUBSCRIBER #  GROUP #  Has any member of your family ever been treated in our office?  Yes No  Whom may we thank for referring you to our office?  METHOD OF PAYMENT  Responsible party currently has an account with this office   Yes No  Payment in full at each appointment (cash or personal check)  Payment in full at each appointment ( VISA MC OTHER Card # Exp. Date   I wish to discuss the Dental Office's Financial Policy	HOME WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
PERSON TO CONTACT IN CASE OF EMERGENCY  Has any member of your family ever been treated in our office?  Yes No  Whom may we thank for referring you to our office?  Whom may we thank for referring you to our office?  METHOD OF PAYMENT  Responsible party currently has an account with this office yes No  AUTHORIZATION  I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental  I wish to discuss the Dental Office's Financial Policy							
PERSON TO CONTACT IN CASE OF EMERGENCY  Name  Address  City/State/ZIP  Telephone #  AUTHORIZATION  I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental  SS#  SUBSCRIBER #  GROUP #  Has any member of your family ever been treated in our office?  Whom may we thank for referring you to our office?  METHOD OF PAYMENT  Responsible party currently has an account with this office  Yes	BIRTHDATE (MO/DAY/YEAR)	RELATIONSHIP TO PATIENT		BIRTHDATE (M	MO/DAY/YEAR)	RELATIONSHIP TO PA	ATIENT
PERSON TO CONTACT IN CASE OF EMERGENCY    Solution   So	EMPLOYER	DENTAL INS. Co	0	EMPLOYER	DENTAL INS. CO		
PERSON TO CONTACT IN CASE OF EMERGENCY    Yes	SS#	SUBSCRIBER#	GROUP#	SS#		SUBSCRIBER#	GROUP #
Yes   No   Whom may we thank for referring you to our office?							
Yes   No   Whom may we thank for referring you to our office?	DEDCON TO CONTACT			Has ar	nv member of vou	r familv ever been tre	ated in our office?
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Payment in full at each appointment (□VISA □MC □OTHER Card # Exp. Date □ I wish to discuss the Dental Office's Financial Policy	Telephone #	<u></u>					
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responsible for all costs of dental treatment. I hereby authorize the Dental    I wish to discuss the Dental Office's Financial Policy		Card # Exp. Date					
	responsible for all costs of dental trea	·					
Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper  SERVICE CHARGE				SERV	ICE CHARGE		
dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the current billing date, a service charge will be added to the account for the billing date, and the billing date, and the billing date will be added to the account for the billing date.							
release my dental/medical histories and other information about my dental monthly billing period. The service charge will be a periodic rate of9	release my dental/medical histories a	nd other information abo	ut my dental	monthly	billing period. The s	ervice charge will be a p	eriodic rate of%
treatment to third party payors and/or other health professionals by any method, including electronic transfer.  per month (or a minimum charge of \$ for a balance under the second party payors and/or other health professionals by any per month (or a minimum charge of \$ for a balance under the second party payors and/or other health professionals by any per month (or a minimum charge of \$ for a balance under the second party payors and/or other health professionals by any per month (or a minimum charge of \$ for a balance under the second party payors and/or other health professionals by any per month (or a minimum charge of \$ for a balance under the second party payors and/or other health professionals by any per month (or a minimum charge of \$ for a balance under the second party payors and or other health professionals by any per month (or a minimum charge of \$ for a balance under the second payor for a balance under			onals by any				
the last month's balance. In the case of default of payment, I promise t				the last	month's balance. I	n the case of default of	payment, I promise to
Patient or Responsible Party pay any legal interest on the balance due, together with any collection of this account or future outstanding accounts.	Patient or Responsible Party			costs a	nd reasonable atto	rney fees incurred to e	

State Driver's License #

Date