

St. Mary's Dental

Name: _____ Date of Birth: _____ SS#: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Name of Family Members _____ Date of Birth _____

Address: _____

Home#: _____ Work# _____ Cell# _____

Email _____

Employer Name _____

Spouse's Employer Name _____

Work#: _____ Cell# _____ Email _____

Person Responsible for Dental Investment: _____ Relation to Patient _____

Whom May We Thank For Referring You to Our Office? _____

INSURANCE INFORMATION

Subscribers Name: _____ SS#: _____

Name of Insurance: _____ Group# _____

EMERGENCY INFORMATION

Physicians Name: _____ Phone#: _____

Emergency Contact and Relationship: _____ Phone #: _____

INFORMATION RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's care) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. If patient is a minor, the doctor has my permission to treat _____ in my absence. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill of services. I understand that I am financially responsible for payments in full of my accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for services not paid, in whole or in part, by my dental care payer. I attest to the accuracy of the information on this page. I understand that, where appropriate, credit bureau reports may be obtained. AFEE MAY BE CHARGED FOR MISSING AN APPOINTMENT OR CANCELLING AN APPOINTMENT WITH LESS THAN 48 HOURS NOTICE. WE RESERVE THE RIGHT TO COLLECT CERTIFIED MAIL FEES, COLLECTION FEES AND LEGAL FEES.

PATIENT OR GUARDIAN'S SIGNATURE _____ DATE _____