Patient Information

Name (First, Middle, Last):	
Home Address (Address, City, Province, Postal Code):	
Home Phone:	Cell Phone:
Email:	Birthday (mm/dd/yyyy):
Emergency Contact:	Phone:

Insurance Information

Employer:	
Occupation:	
Address:	
Spouse Name:	Birthday (mm/dd/yyyy):
Employer:	
Occupation:	
Address:	

I authorize release of any information concerning my (and/or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (and/or my child's) health care, advice, and treatment to another dentist and clinical staff.

I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of accounts at date treatment is rendered. By signing this statement, I revoke all previous to the contrary and agree to be responsible for payment of services not paid*, in whole or in part by my dental payer.

I attest to the accuracy of the information on this page.
By typing my name below I agree to be bound to the term and contents of this form.

Patient's or Guardian's signature:

Date (mm/dd/yyyy):

*There will be an interest charge of 5% compounded monthly on accounts 30 days past due.