

MT. TABOR DENTAL, L.L.C.

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M DOMESTIC PARTNER

ADDRESS _____
STREET APT # CITY STATE ZIP

TELEPHONE _____
HOME # WORK # CELL OR PAGER # EMAIL #

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____
MONTH DAY YEAR

PLACE OF EMPLOYMENT _____ WORK ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

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
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST NAME FIRST NAME M
STREET CITY STATE ZIP
HOME # WORK # CELL/PAGER #
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO./ADDRESS
SOCIAL SECURITY NUMBER SUBSCRIBER NUMBER GROUP NUMBER

SECONDARY INSURED

LAST NAME FIRST NAME M
STREET CITY STATE ZIP
HOME # WORK # CELL/PAGER #
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO./ADDRESS
SOCIAL SECURITY NUMBER SUBSCRIBER NUMBER GROUP NUMBER

EMERGENCY CONTACT

Outside of Immediate Family Household

Name _____

Address _____

City/State/Zip _____

Telephone Number _____

Has any member of your family ever been treated in our office?

YES NO

Whom may we thank for referring you to our office?

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 to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper 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 release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
PATIENT OR RESPONSIBLE PARTY

DATE STATE DRIVER'S LICENSE #

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

I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within 90 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18%, applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.