PATIENT INFORMATION

NAME ____________________ ❑ Male ❑ Female ❑ Married ❑ Single

BIRTHDATE ____________________ SOCIAL SECURITY # ____________________

MONTH DAY YEAR

ADDRESS ____________________

STREET CITY STATE ZIP

TELEPHONE - HOME ____________ WORK ____________ CELL ____________

EMPLOYER ____________________ ADDRESS ____________________

IF FULL TIME STUDENT, SCHOOL NAME ____________________

PERSON RESPONSIBLE FOR ACCOUNT: ❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ GUARDIAN

INSURANCE INFORMATION

IF NO INSURANCE, PLEASE COMPLETE FOR RESPONSIBLE PARTY INFORMATION

Primary Insurance ____________	**Secondary Insurance** ____________
Address ____________	Address ____________
____________	____________
Ins. Phone # ____________	Ins. Phone # ____________
Policy Holder ____________	Policy Holder ____________
Insured's Date of Birth ____________	Insured's Date of Birth ____________
Patient ID/SS# ____________	Patient ID/SS# ____________
Group Number ____________	Group Number ____________
Relationship of Patient to Insured ____________	Relationship of Patient to Insured ____________

Has any member of your family ever been treated in our office? ❑ YES ❑ NO

Whom may we thank for referring you to our office? ____________________

Nearest friend or relative not living in your household ____________________

NAME PHONE

METHOD OF PAYMENT

❑ Payment in full at each appointment (cash , check or credit card)

❑ Care Credit

❑ I wish to discuss the Dental Office's Financial Policy

If the account balance is not paid within 90 days of service, interest charges will accrue at 18% APR. In 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.

AUTHORIZATION

I acknowledge that the above information is correct and true. I hereby authorize Dr. Todd D. Magleby, D.M.D., Dr. Kip Jones, D.D.S., or Dr. Robert W. Winegar, D.M.D. to release all information concerning my (or my child's) dental treatment to my insurance company and/or other health professionals. I also authorize photocopies/fax copies of this form to be as valid as the original. I authorize release of any information concerning my (or my child's) dental care, advise and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

SIGNATURE ____________________

PATIENT OR RESPONSIBLE PARTY

DATE ____________________ DRIVER'S LICENSE # ____________________