



DENTAL CENTER

Date _____

PATIENT INFORMATION

MALE FEMALE MINOR MARRIED SINGLE

Name _____ Email _____
Last First M

Address _____
Street Apt# City State Zip

Birth Date _____ SSN/ID # _____
Month Day Year

Home Phone _____ Work Phone _____ Cell Phone _____

If Full Time Student, School Name _____ Grade _____

PERSON RESPONSIBLE FOR ACCOUNT

PATIENT GUARDIAN SPOUSE FATHER MOTHER

Name _____ SSN/ID # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____
Street City State Zip

DENTAL INSURANCE INFORMATION

Name of Insured _____ Is Insured a Patient at The Dental Center? YES NO
Last First M

Birth Date _____ SS # _____ Ins ID # _____

Primary Insurance Plan Name _____ Ins Group # _____

Insured Address _____
Street City State Zip

Insured Employer Name _____

Employer's Address _____

Secondary Insurance _____ Name of Insured _____

Address _____ Birth Date _____ Relationship _____

SS # or Ins. ID # _____ Ins. Group # _____

Employer _____ Employer's Address _____

IMPORTANT INFORMATION

- There is a charge for missed or broken appointments, without 24 hour advanced notice.
- I understand that I am responsible for all costs of dental treatment. Payment is due at the time services are rendered unless arrangements have been approved in advance by our staff.
- We accept Cash, Checks, Credit or Debit Cards.
- Returned checks and balances older than 90 days will be subject to additional collections and legal fees.
- We will be happy to help you process your insurance for reimbursement. Please be aware that our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. I hereby authorize payment directly to "The Dental Center" of the group insurance benefits otherwise payable to me.
- I hereby authorize "The Dental Center" to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care.
- We provide our patients the option to participate in our online patient communication system. Including but not limited to: requesting appointments online, confirming appointments via email and text, receiving appointment reminders and satisfaction surveys.
- 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 payers and/or other health professionals in accordance with HIPPA.

X _____ Date _____
Patient or Responsible Party