PATIENT INFORMATION

DATE:_____

NAME_____ [] MARRIED [] SINGLE [] MINOR [] MALE [] FEMALE
LAST FIRST M

ADDRESS_____
STREET APT.# CITY STATE ZIP

BIRTH DATE_____ TELEPHONE _____
MONTH DAY YEAR HOME CELL WORK EXT.

E-MAIL_____ Would you like e-mail confirmations? Yes_____ No_____

DENTAL INSURANCE CO_____ GROUP#_____

PLACE OF EMPLOYMENT_____ SS#_____ ID#_____

FAMILY INFORMATION

CHILD'S FATHER (OR PATIENT'S HUSBAND)	**CHILD'S MOTHER (OF PATIENT'S WIFE)**
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME PHONE# CELL # WORK # EXT	HOME PHONE CELL# WORK# EXT
BIRTHDAY (MO/DAY/YEAR) SS# ID#	BIRTHDAY (MO/DAY/YEAR) SS# ID#
EMPLOYER	EMPLOYER
DENTAL INSURANCE CO. GROUP #	DENTAL INSURANCE GROUP #

AUTHORIZATION

I hereby authorize payment of the group insurance benefits otherwise payable to me to be paid directly to Dr. William Brown. The information on this page and the medical/dental histories are correct to the best of my knowledge.
I grant the right to release information about my dental treatment to my insurance carrier and other health professionals as needed during my treatment.

SERVICE CHARGE

If I do not pay the entire balance due on any monthly statement by the due date, a service charge will be added to the account. This also applies to any insurance portion that is not received from m y insurance carrier within 60 days. 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 case of default of payment, I will 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.

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

PERSON RESPONSIBLE FOR ACCOUNT

Please check one

[ ] **Patient** [ ] **Father (or Husband)**
[ ] **Guardian** [ ] **Mother (or Wife**

Has the person responsible for the account been seen as a patient in our office [ ] Yes [ ] No

X_____
[] ADULT [] FATHER/HUSBAND [] MOTHER/WIFE [] GUARDIAN
Signature here please