ACCOUNT INFORMATION AND INSURANCE

LAST NAME ______ FRIST NAME ______ MIDDLE ______

DATE OF BIRTH ______ MALE FEMALE ______ NICK NAME ______

ADDRESS ______ CITY ______ STATE ______ ZIP ______ PHONE ______

OCCUPATION ______ EMPLOYED BY ______ SSN ______

BUSINESS ADDRESS ______ CITY ______ STATE ______ ZIP ______ PHONE ______

SPOUSE'S NAME ______ FRIST NAME ______ DATE OF BIRTH ______

OCCUPATION ______ EMPLOYED BY ______ SSN ______

BUSINESS ADDRESS ______ CITY ______ STATE ______ ZIP ______ PHONE ______

PERSON TO CONTACT IN CASE OF EMERGENCY ______ PHONE ______

INSURANCE INFORMATION

PRIMARY/ EMPLOYEE

SUBSCRIBER NAME ______ BIRTHDATE ______ GROUP # ______

INSURANCE COMPANY ______ ADDRESS ______ PHONE ______

SCEONDARY/SPOUSE

SUBSCRIBER NAME ______ BIRTHDATE ______ GROUP # ______

INSURANCE COMPANY ______ ADDRESS ______ PHONE ______

RESPONSIBLE PARTY FOR PAYMENT OF SERVICES IF OTHER THEN THE PATIENT

NAME ______ RELATIONSHIP TO PATIENT ______ SSN ______

ADDRESS ______ CITY ______ STATE ______ ZIP ______ PHONE ______

EMPLOYER ______ CITY ______ STATE ______ ZIP ______ PHONE ______

ASSIGNMENT & RELEASE ; I hereby authorize my insurance benefits to be paid directly to th dentist. I authorize the release of such information as required for insurance reimbursement. I understand that I am financially responsible for any balance due and that payment from my insurance carrier is subject to my deductible, yearly maximum and eligibility at the time the services are rendered. Futhermore, I understand that a 1% monthly interest rate is assessed on all amounts due over 90 days. In the event of default, I promise to pay all legal cost and reasonable attorney fees as may be required to effect collection of this note.

Date ______ signature of patient,parent or responsible party ______