NAME				DATE		
FIRST	MI	LAST		STATE/	ZIP/	
ADDRESS		CITY		PROV.	P.C.	
E-MAIL	CELL PHONE		_ HOME P	HONE		
SS#/SIN	_BIRTHDATE		-			
CHECK APPROPRIATE BOX:	MINOR SINGLE	MARRIED I	DIVORCED	WIDOW		
IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL					STATE/ PROV	
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER				WORK PHONE / 7IP/		
BUSINESS ADDRESS		CITY		STATE/ PROV	ZIP/ P.C	
SPOUSE OR PARENT'S/GUARDIAN'S NAMEEMPLOYER WORK PHONE					NE	
WHOM MAY WE THANK FOR RE	FERRING YOU?					
PERSON TO CONTACT IN CASE OF AN EMERGENCY					_ PHONE	
RESPONSIBLE PARTY					7	
				RELATIONSHII	Þ	
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT				TO PATIENT		
			HOME P	PHONE		
DRIVER'S LICENSE #	BIRTHDATI					
EMPLOYER				HONE		
				-		
			2.02			
IS THIS PERSON CURRENTLY A	PATIENT IN OUR OFFICE	? YES	□ NO			
INCLIDANCE INCODMAT		? YES	□ NO			
		? YES	□ NO			
INSURANCE INFORMAT		? YES		RELATIONSHI	P	
INSURANCE INFORMAT	TION	? YES		TO PATIENT_		
INSURANCE INFORMATION NAME OF INSURED	TION  SS#/SIN			TO PATIENT_ DATE EMPLOY	YED	
INSURANCE INFORMATE  NAME OF INSURED  BIRTHDATE	TION  SS#/SIN	N OR LOCAL #		TO PATIENT_ DATE EMPLOY WORK PHONI	YED	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS	TION  SS#/SIN			TO PATIENT_ DATE EMPLOY	YED	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS	TION  SS#/SIN	N OR LOCAL #		TO PATIENT_DATE EMPLOY WORK PHONI STATE/ PROV POLICY / I.D.	YEDE ZIP/P.C	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.	TION  SS#/SIN UNION	N OR LOCAL # CITY GRP #		TO PATIENT_ DATE EMPLOY WORK PHONI STATE/ PROV	YEDEZIP/ P.C	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.  INS. CO. ADDRESS	TION  SS#/SIN UNION  TEL. #	N OR LOCAL # CITY GRP #		TO PATIENT_DATE EMPLOY WORK PHONI STATE/ PROV POLICY / I.D.	YEDE ZIP/ P.C# ZIP/ P.C	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.  INS. CO. ADDRESS	TION  SS#/SIN UNION  TEL. #  BLE? HOW MUC	N OR LOCAL #CITY GRP #CITYCITYCH HAVE YOU USED?		TO PATIENT_ DATE EMPLOY WORK PHONI STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL	YEDE ZIP/ P.C # ZIP/ P.C BENEFIT?	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.  INS. CO. ADDRESS  HOW MUCH IS YOUR DEDUCTION  DO YOU HAVE ANY ADDITI	TION  SS#/SIN UNION  TEL. #  BLE? HOW MUC	N OR LOCAL #CITY GRP #CITYCITYCH HAVE YOU USED?	IF YES,	TO PATIENT_ DATE EMPLOY WORK PHONI STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL	YED	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.  INS. CO. ADDRESS  HOW MUCH IS YOUR DEDUCTION  DO YOU HAVE ANY ADDITION  NAME OF INSURED	TION  SS#/SIN UNION  TEL. #  BLE? HOW MUC	N OR LOCAL #CITY GRP #CITYCITYCH HAVE YOU USED?	IF YES,	DATE EMPLOY WORK PHONI STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL COMPLETE RELATIONSHI	YEDE ZIP/ P.C# ZIP/ P.C # ZIP/ P.C BENEFIT? THE FOLLOWING: P	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.  INS. CO. ADDRESS  HOW MUCH IS YOUR DEDUCTIN  DO YOU HAVE ANY ADDIT!  NAME OF INSURED  BIRTHDATE	SS#/SIN UNION  TEL. #  BLE? HOW MUCHONAL INSURANCE?   SS#/SIN	N OR LOCAL #CITY GRP #CITYCH HAVE YOU USED? YESNO	IF YES,	DATE EMPLOY WORK PHONI STATE/ PROV  POLICY / I.D. STATE/ PROV  MAX ANNUAL  COMPLETE  RELATIONSHI TO PATIENT_ DATE EMPLOY	YEDE ZIP/_P.C # ZIP/_P.C BENEFIT? THE FOLLOWING: P YED	
INSURANCE INFORMAT  NAME OF INSURED BIRTHDATE NAME OF EMPLOYER EMPLOYER ADDRESS INSURANCE CO INS. CO. ADDRESS HOW MUCH IS YOUR DEDUCTION DO YOU HAVE ANY ADDIT!  NAME OF INSURED BIRTHDATE NAME OF EMPLOYER	SS#/SIN UNION  TEL. #  BLE? HOW MUCHONAL INSURANCE?   SS#/SIN	N OR LOCAL # CITY CITY CITY CH HAVE YOU USED? YES  NO	IF YES,	DATE EMPLOY WORK PHONI STATE/ PROV  POLICY / I.D. STATE/ PROV  MAX ANNUAL  COMPLETE  RELATIONSHI TO PATIENT_ DATE EMPLOY WORK PHONI STATE/ WORK PHONI STATE/	YEDE	
INSURANCE INFORMAT  NAME OF INSURED BIRTHDATE NAME OF EMPLOYER EMPLOYER ADDRESS INSURANCE CO INS. CO. ADDRESS HOW MUCH IS YOUR DEDUCTING DO YOU HAVE ANY ADDITING NAME OF INSURED BIRTHDATE NAME OF EMPLOYER EMPLOYER ADDRESS	TION  SS#/SIN UNION  TEL. #  BLE? HOW MUCHONAL INSURANCE?  SS#/SIN UNION	N OR LOCAL # CITY GRP # CITY CH HAVE YOU USED? YES NO N OR LOCAL # CITY	IF YES,	DATE EMPLOY WORK PHONI STATE/ PROV  POLICY / I.D. STATE/ PROV  MAX ANNUAL  COMPLETE  RELATIONSHI TO PATIENT_ DATE EMPLOY WORK PHONI STATE/ PROV  WORK PHONI STATE/ PROV	YEDEZIP/ P.C BENEFIT? THE FOLLOWING: P  YED YED EZIP/ P.C	
INSURANCE INFORMAT  NAME OF INSURED BIRTHDATE NAME OF EMPLOYER EMPLOYER ADDRESS INSURANCE CO INS. CO. ADDRESS HOW MUCH IS YOUR DEDUCTION DO YOU HAVE ANY ADDIT!  NAME OF INSURED BIRTHDATE NAME OF EMPLOYER EMPLOYER ADDRESS INSURANCE CO INSURANCE CO	SS#/SIN UNION  TEL. #  BLE? HOW MUCHONAL INSURANCE?   SS#/SIN	N OR LOCAL # CITY CH HAVE YOU USED? YES  NO  N OR LOCAL # CITY GRP # GRP # CITY OR LOCAL # CITY GRP #	IF YES,	TO PATIENT_ DATE EMPLOY WORK PHONI STATE/ PROV  POLICY / I.D. STATE/ PROV  MAX ANNUAL  COMPLETE  RELATIONSHI TO PATIENT_ DATE EMPLOY WORK PHONI STATE/ PROV  POLICY / I.D.	YEDEZIP/_P.C BENEFIT? THE FOLLOWING: P  YED EZIP/_P.C  YED EZIP/_P.C #	
INSURANCE INFORMAT  NAME OF INSURED BIRTHDATE NAME OF EMPLOYER EMPLOYER ADDRESS INSURANCE CO INS. CO. ADDRESS HOW MUCH IS YOUR DEDUCTING DO YOU HAVE ANY ADDITING NAME OF INSURED BIRTHDATE NAME OF EMPLOYER EMPLOYER ADDRESS	TION SS#/SINUNION TEL. #  BLE?HOW MUC  IONAL INSURANCE? SS#/SINUNION TEL. #	N OR LOCAL # CITY GRP # CITY CH HAVE YOU USED? YES NO N OR LOCAL # CITY	IF YES,	DATE EMPLOY WORK PHONI STATE/ PROV  POLICY / I.D. STATE/ PROV  MAX ANNUAL  COMPLETE  RELATIONSHI TO PATIENT_ DATE EMPLOY WORK PHONI STATE/ PROV  WORK PHONI STATE/ PROV	YEDEZIP/_P.C  #ZIP/_P.C BENEFIT? THE FOLLOWING: P  YED EZIP/_P.C #ZIP/_P.C	

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Account balances over 90 days may be subject to a service charge of 1 ½ % per month.

	Date
Patient/Guardian signature	
Subscriber	
We are required by law to maintain the privaction notice of our legal duties and privacy practi	
	knowledgement that you have been offered a
copy of our HIPPA Notice of Privacy Pra	ctices.
	Date
Signature	