NAME				DATE		
NAMEFIRST	MI	LAST		DATE STATE/	7ID/	
ADDRESS		CITY		PROV.	ZIP/ P.C	
E-MAIL	CELL PHONE		_ HOME P	HONE		
SS#/SIN	_BIRTHDATE					
CHECK APPROPRIATE BOX:	MINOR SINGLE	MARRIED I	DIVORCED	WIDOW	Control of the Contro	
IF COLLEGE STUDENT, F.T. / P.T	., NAME OF SCHOOL			CITY	STATE/ PROV	
ATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER				WORK PHONE / 7IP/		
BUSINESS ADDRESS		CITY		STATE/ PROV	ZIP/ P.C	
SPOUSE OR PARENT'S/GUARDIA	N'S NAME	EMPLOYER		WORK PHO	NE	
WHOM MAY WE THANK FOR REI	FERRING YOU?					
PERSON TO CONTACT IN CASE OF AN EMERGENCY				_ PHONE		
RESPONSIBLE PARTY						
			F	RELATIONSHI	IP.	
NAME OF PERSON RESPONSIBI	ME OF PERSON RESPONSIBLE FOR THIS ACCOUNT			TO PATIENT		
ADDRESS	HOME		HOME PI	PHONE		
DRIVER'S LICENSE #	BIRTHDATE		SS#/SIN	SS#/SIN		
EMPLOYER			WORK DI	WORK PHONE		
CIVIF LOTEN			_ WORK PI	IOIL		
IS THIS PERSON CURRENTLY A	PATIENT IN OUR OFFICE	? YES	NO			
		? YES	-			
IS THIS PERSON CURRENTLY A		? YES	□ NO		ID.	
IS THIS PERSON CURRENTLY A I		? YES	NO NO	RELATIONSHI	IP	
IS THIS PERSON CURRENTLY A I		? YES	□ NO	RELATIONSH		
INSURANCE INFORMATIONAME OF INSURED	SS#/SIN		NO NO	RELATIONSHI	YED	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER	SS#/SIN	N OR LOCAL #	NO NO	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/	YEDE	
INSURANCE INFORMATION  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS	SS#/SIN UNION	N OR LOCAL #	NO NO	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV	YEDE ZIP/ P.C	
INSURANCE INFORMAT  NAME OF INSURED  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.	SS#/SINUNION	N OR LOCAL # CITY GRP #	NO NO	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV	YEDE_ZIP/ P.C#	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.  INS. CO. ADDRESS	SS#/SINUNIONTEL. #	N OR LOCAL # CITY GRP # CITY	NO NO	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV POLICY / I.D. STATE/ PROV	YEDE ZIP/ P.C#	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.  INS. CO. ADDRESS	SS#/SINUNION  TEL. #  BLE?HOW MUC	N OR LOCAL #CITY GRP #CITYCITYCH HAVE YOU USED?	NO NO	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL	YED  E  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	SS#/SINUNION  TEL. #  BLE?HOW MUC	N OR LOCAL #CITY GRP #CITYCITYCH HAVE YOU USED?	IF YES,	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL	YEDEZIP/_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 ADDITI	SS#/SINUNION  TEL. #  BLE?HOW MUC	N OR LOCAL #CITY GRP #CITYCITYCH HAVE YOU USED?	IF YES,	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL COMPLETE	YEDEZIP/_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 ADDITION  NAME OF INSURED	SS#/SINUNION  TEL. #  BLE?HOW MUC	N OR LOCAL #CITY GRP #CITYCITYCH HAVE YOU USED?	IF YES,	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL COMPLETE RELATIONSH	YEDE ZIP/ P.C#  ZIP/ P.C # ZIP/ P.C BENEFIT? THE FOLLOWING: IP	
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 BIRTHDATE BIRTHDATE	SS#/SIN UNION  TEL. #  BLE? HOW MUC  ONAL INSURANCE?   SS#/SIN	N OR LOCAL #CITY GRP #CITYCITYCH HAVE YOU USED?	IF YES,	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL COMPLETE RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON	YEDEZIP/_P.C BENEFIT? THE FOLLOWING: IP  YED	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.  INS. CO. ADDRESS  HOW MUCH IS YOUR DEDUCTIF  DO YOU HAVE ANY ADDIT!  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER	SS#/SIN UNION  TEL. #  BLE? HOW MUC  ONAL INSURANCE?   SS#/SIN	N OR LOCAL # CITY GRP # CITY CH HAVE YOU USED? YES \[ \] NO	IF YES,	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL COMPLETE RELATIONSHI TO PATIENT_ DATE EMPLO	YEDEZIP/_P.C BENEFIT? THE FOLLOWING: IP  YED	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.  INS. CO. ADDRESS  HOW MUCH IS YOUR DEDUCTIF  DO YOU HAVE ANY ADDIT!  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  EMPLOYER ADDRESS	SS#/SIN UNION  TEL. #  BLE? HOW MUC  ONAL INSURANCE?   SS#/SIN	N OR LOCAL # CITY GRP # CITY CH HAVE YOU USED? YES  NO	IF YES,	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL COMPLETE RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV POLICY / I.D.	YEDEZIP/_P.C BENEFIT? THE FOLLOWING: IP  YED YED IEZIP/_P.C IEZIP/_P.C P.C #	
INSURANCE INFORMAT  NAME OF INSURED  BIRTHDATE  NAME OF EMPLOYER  EMPLOYER ADDRESS  INSURANCE CO.  INS. CO. ADDRESS  HOW MUCH IS YOUR DEDUCTION	SS#/SIN UNION  TEL. #  BLE? HOW MUC  ONAL INSURANCE?   SS#/SIN UNION	N OR LOCAL # CITY CITY CH HAVE YOU USED? YES  NO N OR LOCAL # CITY	IF YES,	RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV POLICY / I.D. STATE/ PROV MAX ANNUAL COMPLETE RELATIONSHI TO PATIENT_ DATE EMPLO WORK PHON STATE/ PROV DATE EMPLO WORK PHON STATE/ PROV	YEDEZIP/_P.C  BENEFIT? THE FOLLOWING: IP  YED IEZIP/_P.C	

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER

Phave 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. Appointments cancelled or changed within one business day are subject to a cancellation fee. Account balances over 90 days may be subject to a service charge of 1½% per month.

	Date:	
Patient/Guardian Signature		
Subscriber		
		K.*
We are required by law to maintain the privacy of, a of our legal duties and privacy practices with respecting Signature below is only an acknowledgement that you HIPPA Notice of Privacy Practices.	t to protected health	als with this notic
	Date:	
Patient/Guardian Signature	Date.	