Name: ____

Date of Birth:__________________________SSN:__________________________

Address:________________________City________________ Zip Code_________

Contact: Home_________________Work____________Cell___________________

E-mail___________________________ __________________________

Best ways to contact: ____

Employer:____

Dental Benefit Plan (Primary):____
Dental Benefit Plan (Secondary):____

Emergency Contact Person______________________Phone____________________

SPOUSE INFORMATION

Name:____

Date of Birth:________________________SSN:____________________________

Employer:_____________________________________Phone:_________________

FINANCIAL AGREEMENT

Payment for dental treatment is expected on the day of service with cash, check or credit card.

For our patients with dental insurance, we will be happy to file your completed claim with your insurance provider, requesting that your benefit be sent to you directly.

I have read and understand the above information and agree to payment in full on date of treatment.

_________________________________   _________________________________
Signature   Date