

PATIENT INFORMATION

Date: _____

Name _____ () Married () Single () Minor () Male () Female
LAST FIRST MI

Address: _____
STREET APT. # CITY ZIP CODE

Birth Date: _____ Telephone _____
MONTH DAY YEAR HOME WORK MOBILE

SS# _____ Email _____ Employer _____

If FULL TIME STUDENT (SCHOOL NAME) _____ Grade: _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE () Self () Guardian () Spouse () Father () Mother

INSURANCE INFORMATION ADULTS- Complete Primary Insurance _ Dual Insurance: Complete Secondary

Minor child may need to complete both blocks for parent information

PRIMARY INSURANCE

Name _____
LAST FIRST MI

Address _____
STREET APT#

_____ CITY STATE ZIPCODE

Telephone _____
HOME WORK MOBILE

Birth Date _____ Relationship to Pt. _____
MONTH DAY YEAR

Insurance Company _____

Employer _____ Group# _____

SS# _____ Subscriber# _____

Insurance Phone# _____

SECONDARY INSURANCE

Name _____
LAST FIRST MI

Address _____
STREET APT#

_____ CITY STATE ZIPCODE

Telephone _____
HOME WORK MOBILE

Birth Date _____ Relationship to Pt. _____
MONTH DAY YEAR

Insurance Company _____

Employer _____ Group# _____

SS# _____ Subscriber# _____

Insurance Phone# _____

Has any member of your family been treated in our office?
() YES () NO

Whom may we thank for referring you to our office?

AUTHORIAZATION I hereby authorize payment directly to the dental office of the group benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment; I hereby authorize the dental office to administer such medication and perform such diagnostic, photographic, radiographic and therapeutic procedures as may be necessary for proper dental care. The information on this page, the my dental/medical histories and all other information I have provided are correct to the best of my knowledge. I grant the right to the dental practice to release my dental/medical histories and all other information I have provided including any information about my dental treatment to third party payors and other healthcare professionals. **SERVICE CHARGE** All co-payments/fees are due at time of service. Should an insurance co. fail to pay for any procedures, the balance due becomes the responsibility of the patient/guarantor. Any unpaid balance beyond 30 days of the date of service shall be subjected to a service charge of 24% annually. In the case of default the patient/guarantor promises to pay any legal interest on the balance due, together with collection costs and reasonable attorney fees incurred to effect collect of the account or any future accounts. **CANCELLATION POLICY** We require at least 24 hours notice for cancellation of an appointment. If we are not notified within the 24 hours before your appt. is scheduled it is considered a broken appointment. You will be charged a broken appointment fee of up to \$100.00. After 2 broken appointments you will be dismissed from the practice.

EMERGENCY CONACT MUST BE OUTSIDE OF IMMEDIATE FAMILY HOUSEHOLD

Name _____
LAST FIRST MI

Address _____
STREET APT# CITY STATE ZIP

Telephone _____
HOME WORK MOBILE

METHOD OF PAYMENT

Responsible Party currently has an account with this office

() YES () NO

PAYMENT IS DUE IN FULL AT EACH APPOINTMENT

() Cash or Personal Check

() Visa () MasterCard () Discover Exp. Date _____

Credit Card # _____

() Third Party Financing Option
Application and Information provided

CHECKS PAYABLE TO: D. Todd Russell, DDS Inc.

Patient / Guarantor / Responsible Party Signature Date