PATIENT INFORMATION

Date:_________________________

Patient Name:_________________________________Nickname:_______________________

Employer:____________________________Address:_________________________________

Employer Work #:____________________Cell #:___________________

E-Mail:____

Spouse's Name:__________________________Spouse's SS #_________________________

Spouse's Employer:_____________________Address:________________________________

Spouse's Work #:_____________________Cell #:___________________

E-Mail:____

Person Responsible For Account:_______________________Phone #:___________________

Address:____

IF PATIENT IS A MINOR:

Father's Name:_________________________Address:_________________________________

Home #:___________________Work #:__________________SS#_______________________

Employer:_____________________________Address:_________________________________

Mother's Name:________________________Address:__________________________________

Home #:___________________Work #:__________________SS#:_______________________

Employer:_____________________________Address:__________________________________

INSURANCE INFORMATION:

Name of Insurance Co.:_______________________Contract #:_________________________

Subscriber's Name:___________________________Group #:____________________________

Date of Birth:_______________Date of Hire:_________________

Name of Insurance Co.:_______________________Contract #:_________________________

Subscriber's Name:___________________________Group #:____________________________

Date of Birth:_______________Date of Hire:_________________

STATEMENT OF FINANCIAL RESPONSIBILITY:

I authorize Modern Family Dental, PLLC, Dr. Jeffrey P. Dick, DDS to furnish to the named insurance company all information which said insurance company may request concerning my present dental treatment or injury. I also authorize the release of all or part of my dental records to dentists whom I may be referred. I assign to Dr. Jeffrey P. Dick my dental plan benefits for the services rendered. I also understand that I am responsible for a $3.00 rebilling fee placed in my account should I fail to pay my account balance in full within 30 days of the previous billing date. If my account falls 60 days past due, I will be responsible for any collection or legal fees incurred in the pursuit of payment of my account.

Signature:____Date:____________________