WELCOME to our practice! We strive to make your visits pleasant and comfortable.

Please fill in this form completely

PATIENT:

Name:	**Birthdate:**	**Gender:** **Male** ☐ **Female** ☐	
Parent or guardian if child:		**Spouse Name:**	
Address:	**City**	**State**	**Zip Code**
Home Phone:	**Work Phone:**	**Cellphone:**	
SSN#	**E-mail address:**		
Employer:	**Marital Status:** **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐		

PRIMARY INSURANCE INFORMATION/ PERSON RESPONSIBLE FOR ACCOUNT

Name:	**Relation to patient:**	**Phone:**	
Address:	**City:**	**State:**	**Zip Code:**
SSN#	**Gender:** **Male** ☐ **Female** ☐	**Birthdate:**	**E-mail address:**
Employer:	**Work Phone:**	**Cell phone:**	
Insurance Company:	**Subscriber ID #**	**Group #**	
SECONDARY INSURANCE:			
Spouse OR Subscriber name:	**Birthdate:**	**SSN#**	
Employer:	**Work Phone:**	**Cell Phone:**	
Insurance Company:	**Subscriber ID #**	**Group #**	

Person to contact other than the immediate family in case of emergency: ____

Address: ____Phone: ___________________ Relationship: _________________

Who may we thank for referring you to our office? ____

Authorization for release of records: To other health care providers for the purpose of evaluation and/or treatment_________________

AUTHORIZATION AND FINANCIAL ARRANGMENT: Payment is recommended at time of service. Arrangements may be made to set-up a financial agreement prior to treatment. If I do not pay the entire New Balance by the 15th of the month, a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHANGRE will be periodic rate of 1.5% per month, which is an ANNUAL PERCENTAGE RATE of 18% or $1.65, whichever is greater, applied to the unpaid balance. A billing charge may be added to accounts billed monthly. In the case of default, I understand the collection agency will add a fee to the unpaid balance. I promise to pay any legal interest on the balance due together with collection costs and reasonable attorney fees incurred to effect collection on this account.

I hereby authorize payment to Integrity Dental from the group insurance benefits otherwise payable to me. I understand the insurance contract is between the insurance company and the holder of the insurance. The Dental Office submits the claim as a courtesy to me. I am responsible for all fees and services rendered to myself and/or my child regardless of any insurance coverage. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY____ Date ___________________