Chart #: _____

Patient Information

Patient Name _____ Date: _____
Last First MI (Preferred Name) Gender

Social Security #: _____ Birth Date: _____ Driver's License #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ E-mail Address: _____

Referred By _____

Preferred Pharmacy _____ **Location** _____

Responsible Party Information

*** Do not fill out if same as above

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ CDL# _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment # City State Zip Code

Emergency Contact

Name Relationship Phone #

Insurance Information

Effective: _____

Primary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ SS or INS- ID #: _____

Insured's Employer Name: _____ Group #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

Insurance Plan Name _____ Address: _____

Effective: _____

Secondary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ SS or INS- ID #: _____

Insured's Employer Name: _____ Group #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

Insurance Plan Name _____ Address: _____

COB: STD / Fee Schedule / Non Duplication

Consent for Services

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I hereby authorize payment directly to Capitol Periodontal Group of the insurance benefits otherwise payable to me.

I have read the above conditions and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian