GET ACQUAINTED QUESTIONNAIRE

In Order For Us To Serve You Better Please Fill In The Following Information Completely

----------PATIENT INFORMATION----------

NAME of PATIENT_____ _____
FIRST M.I. LAST NICKNAME

Home Address _____
City _____
State _____ Zip _____
Home Phone _____ Cell _____
Date of Birth _____
Soc. Sec.# _____ - _____ - _____

Employer _____
Occupation _____
Emp. Address _____
Email Address _____
Work Phone _____

□ Married * □ Single □ Widowed □ Divorced □ Separated
* (Name of Spouse) _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

----------RESPONSIBLE PARTY INFORMATION----------

Person Responsible for Account _____
Relationship to Patient _____ Soc.Sec.#_____-_____-_____
Employer _____ Occupation _____ No. Years Employed _____
Residence _____ How Long? _____
In Case of Emergency, who should we contact? _____Phone_____

----------INSURANCE INFORMATION----------

If you have dental insurance, we will be happy to assist you in processing your claims for whatever benefits you are entitled to. Please realize that your insurance company has an obligation to you and not your dentist. We have no contractual arrangements with insurance carriers, unions or management; therefore, you are responsible to us for payment of services rendered. To aid us in completing your insurance claim, please fill in the following information. Pease discuss your insurance benefits with our business office staff prior to dental treatment.

Insured Name_____ Insured's Soc. Sec.# _____-_____-_____
Insurance Company _____ Group #_____ Insured DOB_____
Insurance Company Address _____
2d Insured Name _____ 2d Insured's Soc.Sec.#_____-_____-_____
2d Insurance Company_____2d Group#_____ 3d Local#_____
2d Insurance Company Address _____
2d Employer Name & Employer's Address _____

Because of increasing delays by insurance companies, our office is unable to accept assignment for dental claims for secondary insurance or treatment covered by major medical insurance. We will be happy to assist you with the necessary forms for filing your claims. The undersigned agrees that on all unpaid balances, a 1.5% monthly bookkeeping fee will be assessed on all past due amounts. The undersigned also agrees to be responsible for all attorney and collection fees necessary to recover any unpaid balances. I understand where appropriate, credit bureau reports may be obtained.

THANK YOU FOR YOUR COOPERATION!

Signature (*Parent's sign if minor)* _____ Date:_____