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 _____ Father's Name_____
City _____ Father's B-Date_____
State _____ Zip _____ Father's Work Phone_____
Phone (H) _____ (C) _____ Mother's Name_____
Child's date of Birth _____ Mother's Work Phone_____

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_____

Our financial policy prevents us from billing a parent that the child does not live with. We regret any inconvenience this may cause and kindly request your cooperation. The parents who request treatment for the child is responsible for all fees for services rendered.

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

If you have dental insurance, we will be happy to assist you in processing your claim 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 #_____ 2d Local#_____
2d Insurance Company Address _____
2d Employer Name & Employer's Address _____

Because of increasing delays by insurance companies, our office will not be able 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 and to assist you in filing your claim. The undersigned agrees that on all past due amounts will be charged 1.5% interest per month on unpaid balance. The undersigned also agrees to be responsible for all attorney and collections fees necessary to collect the amount due. I understand that where appropriate, credit bureau reports may be obtained.

THANK YOU FOR YOUR COOPERATION!

Signature (*Parent's sign if minor)* _____ Date:_____
Updates (date & initial) _____ _____ _____ _____ _____ _____ _____