DENTAL ART

BRUCE A. SPIGNER, D.D.S.

PATIENT INFORMATION

Date: / /

Name_____ Birthdate _____S.S.#_____
HM PHONE_____ CELL PHONE_____WK PHONE_____
HOME ADDRESS _____
CITY_____ STATE_____ ZIP_____
EMPLOYER_____ OCCUPATION_____
Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W (IF MARRIED) SPOUSE'S NAME_____
SPOUSE'S CONTACT NUMBER_____ ☐WK ☐CELL

GUARDIAN

NAME_____HM PHONE_____
CELL PHONE _____ WK PHONE_____
ADDRESS_____STATE_____ZIP_____
Legal Guardianship Papers ? ☐ YES ☐ NO (Copy Attached) Does Patient live with you ? ☐YES ☐NO
Group HM_____ Group HM Address_____
Group HM Contact_____ GH#_____

EMERGENCY CONTACT

Outside of Immediate Family/Household
IN CASE OF AN EMERGENCY WHO MAY WE CONTACT ?_____
HM PHONE_____CELL PHONE _____ WK PHONE_____
ADDRESS_____STATE_____ZIP_____

FINANCIAL RESPONSIBILITY

PERSON RESPONSIBLE FOR ACCOUNT: ☐ Patient ☐ Father (or Husband) ☐ Guardian ☐ Mother (or Wife)
Name_____Birthdate_____S.S.#_____
RELATIONSHIP TO PATIENT _____
LEGAL GUARDIAN___ (COPY ATTACHED) CONTACT NUMBER_____
HM PHONE_____ CELL PHONE_____WK PHONE_____
BILLING ADDRESS_____
CITY_____ STATE _____ ZIP_____
EMPLOYER_____OCCUPATION_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ YES ☐ NO
☐ Payment in Full at each appointment (cash or personal check)
☐ Payment in Full at each appointment ☐ Visa ☐ MC
Card#_____ Exp Date:_____
☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE
If I do not pay the entire balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00), which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

SIGNATURE_____(GUARDIAN/PARENT IF MINOR) DATE_____

As a courtesy, we will accept payment of benefits directly from your insurance company.
Please fill this part out accurately and completely.

PATIENT NAME_____DATE_____

PRIMARY DENTAL INSURANCE

INSURANCE COMPANY NAME _____ GROUP # _____
ADDRESS _____
CITY_____ STATE_____ ZIP_____ PHONE_____
Subscribers Name _____ Subscribers Birthdate _____
Subscribers S.S.#_____ Drivers License#_____
ID# _____ RELATIONSHIP TO PATIENT_____
HM PHONE_____ CELL PHONE_____WK PHONE_____
BILLING ADDRESS_____
CITY_____ STATE _____ ZIP_____
EMPLOYER_____OCCUPATION_____
CITY_____ STATE _____ ZIP_____

STUDENT STATUS

IS PATIENT A FULL TIME STUDENT ? ☐ YES ☐ NO ☐ SCHOOL I.D. ATTCHED
SCHOOL NAME_____
ADDRESS_____
CITY_____STATE_____ ZIP_____

SECONDARY DENTAL INSURANCE

INSURANCE COMPANY NAME _____ GROUP # _____
ADDRESS _____
CITY_____ STATE_____ ZIP_____ PHONE_____
Subscribers Name _____ Subscribers Birthdate _____
Subscribers S.S.#_____ Drivers License#_____
ID#_____RELATIONSHIP TO PATIENT _____
HM PHONE_____ CELL PHONE_____WK PHONE_____
BILLING ADDRESS_____
CITY_____ STATE _____ ZIP_____
EMPLOYER_____OCCUPATION_____
CITY_____STATE_____ ZIP_____

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as they may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge . I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

SIGNATURE_____(GUARDIAN/PARENT IF MINOR) DATE_____

Print Name_____Witness _____

A Referral...is the highest honor a business can receive from a customer.....

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

If not referred how did you hear about our office ? _____