

**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_  MARRIED  SINGLE  MINOR  MALE  FEMALE

ADDRESS \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ PHONE: HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

WHERE WOULD YOU LIKE APPOINTMENTS CONFIRMED: # \_\_\_\_\_ EMAIL \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_ SS# \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE  SELF  GUARDIAN  SPOUSE  MOTHER  FATHER**INSURANCE INFORMATION****PRIMARY INSURED/** IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_

#HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

D.O.B. \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ DENTAL INS. CO. \_\_\_\_\_

SS# \_\_\_\_\_ SUBSCRIBER # \_\_\_\_\_ GROUP# \_\_\_\_\_

**SECONDARY INSURED**

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_

#HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

D.O.B. \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ DENTAL INS. CO. \_\_\_\_\_

SS# \_\_\_\_\_ SUBSCRIBER # \_\_\_\_\_ GROUP \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY**

OUTSIDE OF IMMEDIATE HOUSEHOLD

NAME \_\_\_\_\_

TELEPHONE # \_\_\_\_\_

HAS ANY MEMBER OF YOU FAMILY BEEN TREATED IN OUR OFFICE?

O  NO  YES WHOM? \_\_\_\_\_

HOW WERE YOU REFERRED TO OUR OFFICE?

**AUTHORIZATION**

I hereby authorize payment directly to the dental office of Dr. Thomas R. Gibbs by my insurance company, otherwise payable to me. I understand that I am responsible for all costs of dental treatments. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures that may be necessary for proper dental care. The information on this page and the dental histories are correct to the best of my knowledge.

\_\_\_\_\_  
PATIENT OR RESPONSIBLE PARTY\_\_\_\_\_  
DATE STATE DRIVER'S LICENSE NUMBER**METHOD OF PAYMENT**RESPONSIBLE PARTY CURRENTLY HAD AN ACCOUNT WITH OFFICE  YES  NO PAYMENT IN FULL AT EACH VISIT (CASH OR CHECK) PAYMENT IN FULL AT EACH VISIT (VISA – MC – OTHER) I WISH TO DISCUSS FINANCIAL POLICY**SERVICE CHARGE**

If I do not pay the entire new 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 1.5% per month (or a minimum charge of \$3.00 for a balance under \$200.00) at an annual rate of 18%