Your smile says a lot about you!


Smart


Shy


Wise


Happy


Friendly


Funny


Confident

WELCOME!

Please take a moment to fill out this form as completely as you can. If you have any questions, we'll be glad to help.

PATIENT INFORMATION

Whom May We Thank for Referring You? _____

Name _____ Email _____

Phone: Home _____ Mobile _____ Work _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Birthdate _____

Check Appropriate Box ❑ Minor ❑ Single ❑ Married ❑ Other

Patient's or Parents Employer _____ Work Phone _____

Business Address _____

City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____

Work Phone _____

If Patient is a Student, Name of School/College _____

City _____ State _____

Person to Contact in Case of Emergency _____

RESPONSIBLE PARTY

Name of Person Responsible for Account _____ Relation to Patient _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

Currently a Patient in our Office? _____ Birthdate _____

INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security Number _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Address _____ City _____ State _____ Zip _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Waterfront Dentistry to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I also assign any insurance benefits directly to Waterfront Dentistry for services rendered. I also understand that payment is due in full at time of treatment unless prior arrangements have been approved. In the event that my payment is not received within 30 days of the due date, I agree to pay all costs of collection, including, but not limited to, reasonable attorney fees and interest of 1.75% per month from the date of original service.

_____ _____

Signature (or parent's signature if patient is a minor) Date