

Patient Information

Name _____
Last first middle

Social Security Number _____

Patient Birth Date _____

Address _____
Street Apt#

City _____

State _____ Zip _____

Home Phone _____

Work Phone _____

Email Address _____
(Optional)

Employer _____

Employer Address _____

Person Responsible for Account _____

Insurance Information

Primary Insured _____
Last First Middle

Street _____

City _____ State _____ Zip _____

Home # _____ Work# _____ Cell# _____ Fax# _____

Birthdate _____

Relationship to Patient _____

Employer _____

Dental Insurance Company _____

Subscriber SS# _____ Member I.D. # _____ Group# _____

Person to Contact in Case of an Emergency

Name _____

Address _____

City/State/Zip _____

Telephone# _____

Relationship _____

Method of Payment

Payment in full is expected at each appointment (cash or personal check)

Payment in full is expected at each appointment (Visa MC Discover AmEx)

Card# _____ Expiration Date _____

Today's Date _____

Spouse Information

Spouse's Name _____

Social Security Number _____

Address _____
Street Apt#

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____
(Optional)

Work Phone _____

Email Address _____
(Optional)

Employer _____

Employer Address _____

Has any other family member been treated in our office _____

Referral Information

Whom may we thank for referring you to our office _____

Phone# _____

Address _____
Street

City _____ State _____ Zip _____

Financial Agreement/Service Agreement

I, the undersigned, hereby agree to pay the above named dental practice all fees due for services rendered. I understand that I am fully responsible for all charges and payments and that the first visit (consultation and various other services deemed necessary by Dr. Fagan and myself), are non-refundable. Payment is to be made at the time of service regardless of insurance coverage.

I understand that the payment of my bill is my legal obligation as the patient. All filings of insurance papers and confirmation of insurance payments to be made by my insurance company are my responsibility. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow through or confirmation.

If this account is placed in the hands of an attorney for collection, I agree to pay attorney fees of thirty-three and one-third percent of the unpaid principal and interest owing, plus all court costs and interest in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. I further agree to pay returned check charges of \$30.00 per returned check.

Patient Signature

Date