

PATIENT INFORMATION

Date: _____

Name: _____ Married / Single / Male / Female
Last First M

Address: _____ City/State/Zip: _____

Telephone: _____
Home Work Cellphone E-Mail

Birthdate: _____ SSN: _____ Employer: _____

If full-time student, School Name & City: _____ Grade: _____

Whom may we thank for referring you to our office? : _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insured's Name: _____ Birthdate: _____
Last First M

Insured's Address: _____ City/State/Zip: _____

Insured's Telephone: _____
Home Work Cellphone

Insured's Employer: _____ Relationship to Patient : _____

Insurance Co. Name: _____ Insured's ID#: _____ Grp #: _____

SECONDARY INSURANCE:

- Check this box if you have secondary dental insurance and complete the backside of this form.

EMERGENCY CONTACT: _____
Name Relationship to Patient Daytime Phone #

I hereby authorize payment directly to Traverse Dental Associates, P.C. of the group insurance benefits otherwise payable to me, if allowed by my insurance carrier. I hereby authorize Traverse Dental Associates, P.C. to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page is 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. I understand that I am responsible for all costs of dental treatment and that full payment or my co-payment is due at each appointment. In the case of default of payment greater than 60 days, I promise to pay a service charge at a periodic rate of 1.5% per month, which is an annual percentage rate of 18% as well as 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.

X _____
Patient's Signature

_____ State Driver's License #

Date: _____

