Patient Information

Date _____

Name _____ Nickname _____
First M Last

Home Address _____ City _____ State _____ Zip _____

Home Tel # _____ Work Tel # _____ Voice mail/Pager/Cell _____

Employer _____ Employer Tel # _____

Birthdate _____ Social Security # _____ Check appropriate box: ☐ Minor ☐ Single ☐ Married

(Spouse or Parent) Name _____ Tel # _____

Spouse or Parent Employer _____ Work Tel # _____

Person to Contact in Emergency _____ Tel # _____

Whom may we thank for referring you? _____ Tel # _____

Responsible Party

Name of Person responsible for this account _____ Relationship to patient _____

Address _____ Home Tel # _____

Birthdate _____ Employer _____ Work Tel # _____

Social Security # _____

Is this person currently a patient in our office? ☐ YES ☐ NO

Insurance Information

☐ **No Dental Insurance** (See financial arrangements below)

Name of insured (Policy Holder): _____ Relationship to patient _____

Birthdate _____ Social Security # _____

Name of employer _____ Work Tel # _____

Address of employer _____ City _____ State _____ Zip _____

Dental Insurance Co. _____ Group # _____

Address of Ins. Co. _____ Tel # _____

Do you have additional dental insurance? ☐ YES ☐ NO If yes, complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____

Name of employer _____ Work Tel # _____

Address of employer _____ City _____ State _____ Zip _____

Secondary Dental Insurance Co. _____ Group # _____

Address of Ins. Co. _____ Tel # _____

Financial Arrangements and Authorizations

For your convenience we offer the following methods of payment. Please check the option which you prefer.

Payment is due in full at time of service.

_____ Cash _____ Personal Check

_____ Credit Card ___ VISA ___MC _____ Dental Insurance

_____ ***I wish to discuss other payment arrangements, please see office staff (Low Interest Financing)***

I understand that any remaining balance will be due within 25 days of service or a late charge of 1.5% (18% apr) on the balance then unpaid and will be assessed each month. I realize that failure to keep this account current may result in me being unable to receive additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of defaults on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

_____ _____

Signature of patient (or parent, if minor) Date

Thank you for filling out this form completely. This information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

I authorize Robert L. Holloway, DDS, to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other healthcare practitioners.

I authorize and request my insurance company to pay directly to Robert L. Holloway, DDS, insurance benefits otherwise payable to me