PATIENT INFORMATION

Date:_________________________

Patient Name:_________________________________Nickname:_______________________
Employer:____________________________Address:_________________________________
Employer Work #:____________________Cell #:___________________
E-Mail:____

Spouse's Name:_________________________Spouse's SS #_________________________
Spouse's Employer:_____________________Address:________________________________
Spouse's Work #:_____________________Cell #:___________________
E-Mail:____

Person Responsible For Account:_______________________Phone #:___________________
Address:____

IF PATIENT IS A MINOR:
Father's Name:_________________________Address:_______________________________
Home #:___________________Work #:_________________SS#_______________________
Employer:_____________________________Address:_______________________________

Mother's Name:________________________Address:_________________________________
Home #:___________________Work #:_________________SS#:_______________________
Employer:_____________________________Address:_________________________________

INSURANCE INFORMATION:
Name of Insurance Co.:________________________Contract #:_________________________
Subscriber's Name:___________________________Group #:____________________________
Date of Birth:_______________Date of Hire:_________________

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Subscriber's Name:___________________________Group #:____________________________
Date of Birth:_______________Date of Hire:_________________

STATEMENT OF FINANCIAL RESPONSIBILITY:

I authorize Modern Family Dental, PLLC, Dr. Jeffrey P. Dick, DDS to furnish to the named insurance company all information which said insurance company may request concerning my present dental treatment or injury. I also authorize the release of all or part of my dental records to dentists whom I may be referred. I assign to Dr. Jeffrey P. Dick my dental plan benefits for the services rendered. I also understand that I am responsible for a $3.00 rebilling fee placed in my account should I fail to pay my account balance in full within 30 days of the previous billing date. If my account falls 60 days past due, I will be responsible for any collection or legal fees incurred in the pursuit of payment of my account.

Signature:_______________________________________Date:____________________