PLEASE PRINT

STONEGATE MEADOWS
Family, Cosmetic & Implant Dentistry

PATIENT INFORMATION

Name:______________________________ Preferred Name:______________
Last First MI

☐Male ☐Female ☐Single ☐Married ☐Child ☐Other__________ Date of Birth:______-______-______

SS#______-______-______ Phone (Home):__________________ (work):__________________ ext. ________

Address:____
Street Apt.# City State Zip

Employer:____
Company Name Address Occupation

Whom may we thank for referring you to our practice?

☐Dental Office__________________ ☐Patient__________________

☐Friend__________________ ☐Other__________________

Is the Patient a full-time student? ☐Yes ☐No If Yes, name of school:__________________

Person to contact in case of emergency: Relative:__________________ Phone:__________________
Friend:__________________ Phone:__________________

RESPONSIBLE PARTY INFORMATION

Name:______________________________ ☐Male ☐Female
Last First MI

Relationship
to Patient: ☐Spouse ☐Parent ☐Other__________________ Date of Birth:__________________

SS#______-______-______ Phone (Home):__________________ (work):__________________ ext. ________

Address:____
Street Apt.# City State Zip

Employer:____
Company Name Address Occupation

INSURANCE INFORMATION

In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be completely filled out.

PATIENT'S PRIMARY DENTAL INSURANCE

Ins. Co. Name:__________________
Address:__________________
____
Area Code:__________Phone:__________________
Policy Holder:__________________
First Name MI Last Name
SS#:______-______-______ D.O.B:______-______-______
Employer:__________________
Group #:__________________ ID#__________________

PATIENT'S SECONDARY DENTAL INSURANCE

Ins. Co. Name:__________________
Address:__________________
____
Area Code:__________Phone:__________________
Policy Holder:__________________
First Name MI Last Name
SS#:______-______-______ D.O.B:______-______-______
Employer:__________________
Group #:__________________ ID#__________________

Consent for Services: I understand that responsibility for payment of all dental services provided in this office for myself or my dependents is mine. I further understand that a finance charge of 1.5% per month, will be added to any unpaid balance exceeding 90 days, unless previously authorized financial arrangements are satisfied. In the case of default of payment, I promise to pay any interest on the balance due, together with any collection costs and reasonable attorneys fees incurred to effect collection of this account or future outstanding accounts. A $15 service charge will be added for returned checks. I understand that a fee estimate given for dental services can only be extended for a period of six months from the date of the patient examination.

I assign all insurance benefits to the Doctor. This assignment will remain in effect until revoked by me in writing. I hereby authorize said assignee to release all information necessary to secure the payment. I have read the above conditions of treatment and agree to their content.

Patient Signature:__________________ Insured Signature:__________________ Date:__________
(Guardian/Parent if Minor)