COAST DENTAL

PATIENT INFORMATION & AGREEMENT

Patient Name	Social Security Number	Home Phone
Home Address	City, State, ZIP	Birth Date
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	Gender ☐ Female ☐ Male	Cell Phone
Primary Ins. Company	Group #	Subscriber
Secondary Ins. Company	Group #	Subscriber

RESPONSIBLE PARTY'S INFORMATION (IF DIFFERENT FROM ABOVE)

Name	Social Security Number	Home Phone
Home Address	City, State, ZIP	Birth Date
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	Relationship to Patient	Driver's License #
Responsible Person's Employer	Occupation	Work Phone
Business Address	City, State, ZIP	
Spouse's Name	Social Security Number	Birth Date
Spouse's Employer	Spouse's Occupation	Spouse's Work #
Spouse's Business Address	City, State, ZIP	

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Friend ☐ Relative ☐ Insurance Plan ☐ Yellow Pages ☐ Online ☐ TV/Radio ☐ Newspaper Ad ☐ Direct Mail ☐ Sign by Building

☐ Other _____ If you were referred, whom may we thank for referring you? _____

CONSENT

I will answer all health questions to the best of my knowledge. _____ (*initial*)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor my dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays, as deemed necessary and advisable by the doctor.

Signature _____ Date _____ Relationship to Patient _____

AGREEMENT TO PAY

I agree to pay for all services rendered. In the event that payment is not made within thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and reduced benefit, I will be financially responsible to pay up to the agreed upon fee schedule.

Payment Preference ☐ Cash/Check on day of treatment ☐ Credit Card ☐ Debit Card

Signature _____ Date _____

* There may be a charge for any missed appointment not cancelled **24 hours before the appointment time**