PERSONAL/FINANCIAL INFORMATION

Today's Date: ___________

Patient's Name: ____
Mailing
Address: ____
Physical
Address: ____

City: ____________________ State: ______________ Zip: ____________

Home Phone: ______________ Work Phone: ____________ Cell Phone: ____________

Birth Date: ________________ Social Security Number: ______________________

Employer: ______________________________Employer Phone: __________________

Father (Or Husband): ____________________ Address: ______________________

Home Phone: _____________ Work Phone: ____________ Cell Phone: ____________

Date of Birth: _____________ SSN: _________________ Employer: ____________

Mother (Or Wife): ____________________ Address: ______________________

Home Phone: ______________ Work Phone: ____________ Cell Phone: ____________

Date of Birth: ______________ SSN: __________________ Employer: ____________

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INSURANCE INFORMATION:
Employer________________ Policy Holder's Name____________________________
Primary Insurance ______________________________________Policy # ____________
ID #_________Address __________________________________Phone____________
SSN______________________________________DOB______________________

Secondary Insurance ____________________Policy Holder's Name__________________
ID#___________ Address _________________________________Phone____________

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EMERGENCY CONTACT: (Outside of Immediate Family/Household)
Name: ____ Relationship: ____________
Address: ________________________________ Phone: ______________________

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FINANCIAL RESPONSIBILITY:

Authorization:

I hereby authorize payment directly to Sierra Dental, P.C. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment; I also, understand my insurance company is an agreement between myself and my insurance company, not the dental office.

I hereby authorize Sierra Dental, P.C. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are 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.

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month, which is 18% annual. In the case of default of payment, I promise to pay 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.

Responsible Party's Signature: ____________________________ Date: ____________