PATIENT INFORMATION

Date: _____ Best # to contact during the day: _____

Name: _____
Last First MI

Address: _____ City/State/Zip: _____

Telephone: _____/_____/_____/_____
Home **Work** **Cell** **E-Mail**

Preferred method for appointment reminder: ☐EMAIL ☐TEXT ☐CALL

Birthdate: _____ SSN: _____ Sex: ___M ___F

Marital Status: ___Married ___Single ___Divorced ___Widowed Employer: _____

Whom may we thank for referring you to our office? : _____

Responsible Party Information (if other than patient)

Name_____ Same address as patient? ____Y ____ N

Relationship to Patient ___ Spouse ___ Mother ___ Father ___Guardian Social security #_____

Date of Birth_____ Home # _____ Work# _____Cell#_____

Billing Address_____ City _____State_____Zip_____

Home # _____ Work #_____Cell#_____

Who is responsible for making appointments? _____

EMERGENCY CONTACT: _____
Name Relationship to Patient Daytime Phone #

I hereby authorize payment directly to Traverse Dental Associates, P.C. of the group insurance benefits otherwise payable to me, if allowed by my insurance carrier. I hereby authorize Traverse Dental Associates, P.C. to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page is 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. I understand that I am responsible for all costs of dental treatment and that full payment or my co-payment is due at each appointment. In the case of default of payment greater than 60 days, I promise to pay a service charge at a periodic rate of 1.5% per month, which is an annual percentage rate of 18% as well as 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.

X _____ _____
Patient's Signature /Parent's signature State Driver's License #

Date: _____

Over for Dental Insurance Information

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE:

Insured's Name: _____ Birthdate: _____
Last First M

Insured's Address: _____ City/State/Zip: _____

Insured's Telephone: _____
Home Work Cell

Insured's Employer: _____ Relationship to Patient : _____

Insurance Co. Name: _____ Insured's SSN#: _____ Grp #: _____

Insured's ID #:_____

SECONDARY INSURANCE:

Insured's Name: _____ Birthdate: _____
Last First M

Insured's Address: _____ City/State/Zip: _____

Insured's Telephone: _____
Home Work Cell

Insured's Employer: _____ Relationship to Patient : _____

Insurance Co. Name: _____ Insured's SSN#: _____ Grp #: _____

Insured's ID#_____
