WELCOME TO PRIMROSE DENTAL

Name _____ Preferred Name_____Date _____

Address _____City _____ State ____ Zip _____

Birth date _____ Phone ( ) _____ Cell ( ) _____ Marital Status _____

SS# _____ Male _____ or Female _____

Patient Employed by _____ Work Phone _____

Parent or Spouse's name _____

Parent or Spouse's employer _____ Work Phone _____

Person responsible for this account? _____

Who may we thank for referring you? _____

INSURANCE INFORMATION

Name of insured _____ DOB of insured _____
Relationship to patient _____
Insured Employer _____
Insurance Company _____ Phone # _____
Insured SS# _____ Group # _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Name _____ Phone _____

METHOD OF PAYMENT _____
Payment is expected in FULL at each appointment. We will file your insurance claim for you, but we will collect your portion at the time of service. Thank you!

AUTHORIZATION
I hereby authorize payment directly to the Dental office of the benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I am financially responsible for any balances due and authorize the dentist to release any information required about my dental treatment to third party payors and or other health professionals. **A 1.5% per month financial charge will be added to all unpaid accounts over 60 days beginning May 1, 2011.** I understand that if it becomes necessary to refer my account for collections, that I will be responsible for all cost of collection; including legal fees and court costs. I also understand that I can be reported to the credit bureau if I fail to meet my obligation. I authorize the dental office to administer medications and perform procedures as may be necessary for proper dental care. I certify that I have read and understand the contents of this form and do realize the risks and limitations involved.

Patient/Guardian Signature _____ Date _____