PATIENT INFORMATION

Date ____________________

NAME ______________________________ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST MI

SOCIAL SECURITY # ________-________-________ BIRTHDATE ____________________
MONTH DAY YEAR

ADDRESS ____
STREET APT. # CITY STATE ZIP

TELEPHONE ____
Please circle the best way to contact you: HOME WORK CELL

EMAIL ____

NAME OF EMPLOYER ______________________ ADDRESS ______________________

IF FULL TIME STUDENT, SCHOOL NAME ______________________ GRADE __________

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PATENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY	**SECONDARY INSURED**
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME WORK CELL	HOME WORK CELL
BIRTHDATE (MM/DD/YY) RELATIONSHIP TO PATIENT	BIRTHDATE (MM/DD/YY) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INSURANCE CO.	EMPLOYER DENTAL INSURANCE CO.
SSN SUBSCRIBER ID GROUP #	SSN SUBSCRIBER ID GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME ______________________________

ADDRESS ______________________________

CITY/STATE/ZIP ______________________________

TELEPHONE # ______________________________

AUTHORIZATION

I hereby authorize payment directly to Dr. Gary Silva of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Gary Silva 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 and the dental/medical histories are correct to the best of my knowledge. I grant the right to Dr. Gary Silva to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

Has any member of your family ever been treated in our office?
☐ Yes ☐ No
Whom may we thank for referring you to our office?
____

METHOD OF PAYMENT

☐ Co-Payment (To be paid in full at each appointment)
☐ Payment in full at each appointment (No insurance)

Please select one of the following payment options:
☐ Visa ☐ MC ☐ Discover ☐ American Express ☐ CareCredit
☐ Cash or Personal Check

Card # ______________________ Exp Date __________

SERVICE CHARGE
If I do not pay the entire new balance within **60** 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 applied to the last month's balance, which is an annual percentage rate of **22%**.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.

X ______________________________ Date __________ State Driver's License ____________________