Patient Information

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

Social Security #: __________________ Birth Date: ______________ Gender: ______________

Phone (Home): ______________ (Cell): ______________ (Work): ______________ *Ext:* ________

Address: ____
Street Apartment # City State Zip Code

E-Mail Address: ______________________ Name of person referring you: ______________________

Employer Information

Employer Name: ______________________ Occupation: ______________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

Social Security #: ______________________ Birthdate: ____________ ☐ Male ☐ Female

Phone (Home): ______________ (Work): ______________ Ext: ______

Address: ____
Street Apartment # City State Zip Code

Dental Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birthdate: ____________ ID #: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birthdate: ____________ ID #: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

Policy of Care and Payment

Initial

_______**As a condition of your treatment plan by this office, financial arrangements must be made in advance.** Thomas F. McKenny, DDS General Dentist requires payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, cash and check. If you are in need of an extended finance option, we also work with Care Credit and Chase Health Advance Financing Options, who offers a six month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

Initial

_______**Insurance:** You are responsible for the entire balance of any treatment you receive. We will be glad to file your insurance electronically. Due to the large variety of insurance companies and plans, we are unable to determine the exact amount of coverage for each plan at the time of treatment. Your insurance coverage will be estimated and the remaining balance is due at time of treatment.

Initial

_______**Missed Appointment/Late Cancellation:** Please give us the courtesy of 48 hours notice if you are unable to make your appointment. If adequate notice is not given, a Missed appointment/Late Cancellation charge will be applied to your account in the amount of $50.00 for each hour of time scheduled.

I have read the above conditions of treatment and payment and agree to their content.

______________________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian