Personal Information

Welcome to our family thank you for selecting us for your dental needs. In order to gather the information that is needed to establish you as a patient, we ask that you fill out the form below completely. If you have any questions or need assistance, please ask, we are always happy to help.

Personal Information

Name _____ Date of Birth _____
(Last) (First) (Middle Initial)

Phone (Cell) _____ Phone (Other) _____ SS# _____

Home Address _____ City _____ State _____ Zip_____

Drivers License No _____ State _____

Email_____

If you are a student, please list parents name(s) and address(es)_____

_____

Spouse/Family Information

Name of Spouse _____ Date of Birth _____
(Last) (First) (Middle Initial)

SS# _____ Spouse's Employer_____

Children's Names _____

Employment Information

Employer Name _____ Work Phone _____ Ext_____

Occupation _____ May we contact you at work? Yes No

Employer Address _____ City _____ State _____ Zip_____

Emergency Contact Information

Name _____ Phone (Cell) _____

Relationship _____ Address _____

Additional Contact (Name, Phone, Address)_____

OUR OFFICE POLICY is that payment is kindly requested for all expenses at each visit*. Below are the options that we have availalbe for payment. Please initial next to the selection you prefer.*

_____ Credit Card

Account Number: _____ Name on Card: _____

Exp Date: _____ CVV Code: _____

Signature: _____

_____ Dental Insurance

1. **Expenses not covered by your insurance company are required to be paid in full by you prior to receiving treatment.**
   - This would include any deductible amount, co-payment, non-covered service, and products, etc.
2. **Your insurance policy is a contract between your insurance company and you. We have no part in that.**
   - Insurance is a benefit that you or your employer has purchased for you and typically does not cover all charges and may have annual coverage limits.
   - Our concern is in you, not the insurance company. The treatment that we provide is determined by your dental needs and conditions, NOT by your insurance coverage.

Authorizations

1. I hereby authorize Trimble Dental to release any information requested by my insurance company(ies) acquired in the course of treatment.
2. I understand that I am personally financially responsible for ALL charges regardless of my insurance situation and ask Trimble Dental to bill my insurance company for me.
3. I understand that I am expected to pay, at the time of each visit, the portion of my charges that my insurance company would probably not cover, and that I will be required to pay the insurance portion of my charges after 45 days if it is unpaid by my insurance company.
4. I understand that my account will be considered PAST DUE after 45 days of non-payment and a finance charge of 1.5% a month will be added to my account.
5. I understand that I am responsible for any charges incurred with collection/legal fees by this office if I default on my account.
6. I understand that $40 charge will be incurred per check on all returned checks.
7. I understand that if I am using my credit card for payment, I authorize Trimble Dental to bill my credit card directly.
8. I hereby authorize and direct my insurance benefits to be paid directly to this office.
9. I undestand if I fail to show for 2 appointments or cancel 3 appointments within 48 hrs of the appointment, I may no longer be considered a patient of the practice and that this is at the discretion of Trimble Dental.

I have read and understand all of the above.

Print Patient Name

Patient Signature Date

Print Legal Guardian Name

Legal Guardian Signature Date