

**PERSONAL INFORMATION**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

In case of emergency, name of nearest relative: \_\_\_\_\_ Phone: \_\_\_\_\_

**RESPONSIBLE PARTY**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Drivers License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE INFORMATION**

Insureds Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy / or ID #: \_\_\_\_\_ Local: \_\_\_\_\_

**IF DUAL COVERAGE:**

Insureds Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy / or ID #: \_\_\_\_\_ Local: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

I CERTIFY THAT I, AND/OR MY DEPENDENT(S) HAVE INSURANCE COVERAGE AND ASSIGN BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, I AUTHORIZE DR. DAVID VIERHUS AND DR. TERRI BRUMMITT TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. **I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF AND/OR MY DEPENDENTS IS MINE, DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED.** IN THE EVENT OF DEFAULT I (WE) PROMISE TO PAY LEGAL INTEREST ON THE INDEBTEDNESS, TOGETHER WITH SUCH COLLECTION COSTS AND REASONABLE ATTORNEY FEES AS MAY BE REQUIRED TO EFFECT COLLECTION OF THIS NOTE.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment is due in full at time of treatment, unless prior arrangements have been approved.**