

**PATIENT INFORMATION SHEET**

**PATIENT**

Name: \_\_\_\_\_ Sex: M F Marital Status: S M D W Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

SS #: \_\_\_\_\_ Home or Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ E-mail: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Name of General Dentist: \_\_\_\_\_ City: \_\_\_\_\_ How Long? \_\_\_\_\_

Name of Physician: \_\_\_\_\_ City: \_\_\_\_\_ How Long? \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

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

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**Primary**

**Secondary**

Subscriber Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_

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

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

Insurance Co.: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Soc Sec # or ID # \_\_\_\_\_

Soc Sec. # or ID # \_\_\_\_\_

Group #: \_\_\_\_\_

Group #: \_\_\_\_\_

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

**POLICY OF THE OFFICE**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

**APPOINTMENTS**

So that we can maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments. Once you have made an appointment, remember this time is reserved for you. THEREFORE APPOINTMENTS THAT ARE CANCELLED WILL NOT BE CHARGED IF 24-HOUR NOTICE IS GIVEN.

**INSURANCE**

I hereby authorize, Daniel C. Harper, DMD, MS, LLC to furnish the insured's insurance company all information and that said insurance company may request concerning my present illness. I hereby assign to the said doctor all money to which I am entitled for dental expense relative to the services performed, but not to exceed my indebtedness. I understand I am financially responsible to the said doctor for charges not covered by this assignment.

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