x_____
Patient Inital

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can
If you have any questions we'll be glad to help you.

PATIENT INFORMATION

Patient Name _____**DOB**_____ **Gender** [ ] M [ ] F **Married** [ ] Y [ ] N
SSN#_____**Email**_____
Cell Phone_____**Home Phone**_____**Work Phone**_____
Preferred contact method [ ] Hm Phone [ ] Cell Phone [ ] Work Phone [ ] Email
How did you hear about us? (*please be specific so we can thank them!*) _____

If patient is under 18 yrs old, please also complete the following:
Guarantor Name _____**DOB**_____ **Relationship**_____

ADDRESS

Check box if same for entire family [ ]
Address_____
Address 2_____
City_____**State**_____**Zip**_____

PRIMARY INSURANCE POLICY

Patient relationship to subscriber [ ] Self [ ] Spouse [ ] Child, Student Status (19 and over) [ ] Full [ ] Part [ ] Non-student

Subscriber name_____**DOB**_____**SSN#**_____
Insurance Name_____**Subscriber ID#**_____
Employer_____**Group Name**_____**Group#**_____

SECONDARY INSURANCE POLICY

Patient relationship to subscriber [ ] Self [ ] Spouse [ ] Child, Student Status (19 and over) [ ] Full [ ] Part [ ] Non-student

Subscriber name_____**DOB**_____**SSN#**_____
Insurance Name_____**Subscriber ID#**_____
Employer_____**Group Name**_____**Group#**_____

FINANCIAL AGREEMENT

- For my convenience, Center Plaza Dentistry may release my information to my insurance, and receive payment directly from them
- If sent to collections, I agree to pay a **$30 collection fee, all related fees and court costs.**
- Every effort will be made to help me with my insurance, **but if they do not pay as expected, I will still be responsible.**
- Treatment plans may change, and I will be responsible for the work actually done.

Signature_____Date_____

Witness_____Date_____