PATIENT UPDATE

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Name_____
Last Name *First Name* *Initial*

Address_____

City_____State_____Zip_____

Home Phone_____

Cell Phone_____

Business Phone_____

E.MAIL_____

PRIMARY DENTAL INSURANCE_____

SECONDARY DENTAL INSURANCE_____

If you do have a new insurance plan, please present your insurance card to the receptionist.

IF THERE HAVE BEEN ANY RECENT CHANGES IN YOUR HEALTH PLEASE FILL OUT A NEW MEDICAL HISTORY

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment, unless prior arrangements have been approved or procedures have been submitted to insurance. I understand that a 1.33% finance charge will be assessed monthly for any account balance remaining over 60 days. I agree to reimburse the office the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, the office incurs in such collection efforts.

Signature_____ Date_____