New Patient Information. Today's date _____

Patient _____Birthdate_____

Last name First name Middle initial Preferred name

Age _____ Sex: □male □female

Status: □minor □single □married □widowed □separated □divorced □partnered for _____ years

Home phone (_____)_____ Cell phone (_____)_____

Work phone (_____)_____

Which phone numbers can we contact you or leave detailed messages pertaining to you or your

Child/dependent? *Check all that apply* Home □ Cell □ Work □

Email _____ SS# _____ - ____ - _____

Driver's license #_____

Home address _____City_____State_____

ZIP _____

Who may we thank for referring you?

Responsible Party Information.

The *responsible party* is the person obligated to pay the patient's dental bill; it may or may not be the patient listed on this form. You may mark "SAME" if information is the same as you've written in the above section.

Name of responsible party _____

Relationship to patient _____

Check here if the responsible party and insurance information is the same for all family members.

SS# _____ - ____ - _____ Driver's license #_____

Home phone (_____)_____ Cell phone (_____)_____

Email _____

Home address _____

City _____State _____ ZIP _____

Employer _____

Occupation _____

Primary Dental Insurance Company.

Company name _____ Subscriber's name

Subscriber's birthdate _____ Subscriber's Social Security # _____ - _____ - _____

Subscriber's ID # _____

Subscriber's address (if different than above)

Official Financial Agreement. Today's visit will be paid by: □Cash □Check □Credit Card *(all major credit cards)*

All fees for service are due at the time of the initial appoinment. All returned checks must be paid in cash within 10 days with a service charge of $35. Dental insurance can be processed with the following conditions: The office must be able to verify coverage or the entire payment for services will need to be paid at the current appointment. Secondary insurance can be filed for you, but you will be responsible for paying this as most secondary insurance is sent directly to the subscriber. Any charges not paid by the insurance remain the responsibility of the patient. A dental plan is nothing more than a contract between the employer and the insurance company to partially pay for certain services. We will file your insurance as a courtesy for our patients, with the mutual understanding that all fees unpaid by the insurance company are the immediate responsibility of the patient.

I, the undersigned, certify that I (or my dependent) have dental insurance, and assign directly to Unsil Keiser, DDS, P.A., all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

X _____

Signature (for financial responsibility) Date

I grant my permission to you or your assignee, to telephone me at home or at my work and discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content. If I am unable to keep the appointment, I realize that a 48-hour notice is required. Without proper notification, I will agree to pay the current office visit charge.

X _____

Signature Date

□There are no updates or changes to my information.

Date _____ *Signature* _____