Southwest
Dental Associates

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Patient Information *(confidential)* **Today's Date** _____

Patient Name_____ Birth Date _____

Home Phone _____ Cell Phone_____ Email_____

Address_____ City _____State_____ Zip_____

Check Appropriate: __ Minor __Single __Married __Widowed

Patient or Parent's Employer:_____ Position _____SS#_____-____-_____

Business Address_____ City_____ State _____Zip_____

Emergency Contact_____Relationship_____ Phone _____

Responsible Party *(if patient is a minor)*

Name of person responsible for account_____ Relationship to patient_____

Address_____ City_____ State_____ Zip_____

Birth Date_____ SS# _____-_____-_____ Employer Phone _____

Dental Insurance Information

Name of insured_____Relationship to patient_____

Birth Date_____ SS# _____- _____- _____ Date effective _____

Name of Employer_____ Work Phone_____

Insurance Company_____ Group # _____

Insurance Co. Address_____ City_____ State_____ Zip_____

Please fill out if you know your policy benefits:

Percentage of: Preventative _____ Basic_____ Major _____ Insurance Fiscal Year Date_____

Limits on : Cleanings_____ Flouride Treatments_____ X–Rays_____

Amount of deductible: $_____ Maximum annual benefit: $ _____ Amount remaining: $_____

Assignment and release: I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Southwest Dental Associates all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Southwest Dental Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

Signed _____ **Date** _____

I understand the responsibility for payment for dental services provided in this office for me or my dependents is mine, due and payable at the time services are rendered. I further understand that 1½% finance charge per month (18% annually) will be added to any balance over 60 days. In the event of default, I/we promise to pay legal interest on the indebtedness, together with collection costs and attorney fees as may be required to effect collection on this note. I certify that the above information is true and correct and consent to a credit check based on that information. I agree to be, and hereby am, fully responsible for the total payment of the charges for procedures performed in this office, including any amounts not covered by any dental insurance or prepayment plan that I/my spouse may have.

Signed_____ **Date**_____