Riverview Dental

PATIENT INFORMATION DATE ______________

PATIENT ____ ___ ___ BIRTHDATE ____________ SOC. SEC. # ______________
FIRST MI LAST M F

ADDRESS ____ CITY ______________________ STATE ________ ZIP __________

HOME PHONE ______________________ CELL ______________________ EMAIL __________________________________

COMMUNICATION PREFERENCES - CHECK ALL THAT APPLY: TEXT MESSAGES ____ EMAILS ____ PHONE CALLS ____

CHECK APPROPRIATE: ____ MINOR ____ SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED ____ SEPARATED

PATIENT'S EMPLOYER ____ WORK PHONE ______________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ________________________________ PHONE(S) ______________________

HOW DID YOU HEAR ABOUT US? ____

SPOUSE OR PARENT'S NAME ________________ SPOUSE'S EMPLOYER ________________ SPOUSE'S WORK PHONE ____________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________________________________ RELATIONSHIP TO PATIENT ______________

ADDRESS ____ CITY ______________________ STATE ________ ZIP __________

HOME PHONE __________________ CELL PHONE __________________ BIRTHDATE ____________ SOC. SEC. # ______________

NAME OF EMPLOYER ____ WORK PHONE ______________________

DO YOU HAVE DENTAL INSURANCE? ____ YES ____ NO **IF YES, COMPLETE THE FOLLOWING:**

FAMILY COVERAGE ____ OR SINGLE COVERAGE ____

POLICYHOLDER ____ RELATIONSHIP TO PATIENT ______________

POLICYHOLDER'S ADDRESS ____

BIRTHDATE ________ SOC. SEC. # __________________ NAME OF EMPLOYER __________________ WORK PHONE ____________

INSURANCE COMPANY ______________________________________ ID# ____________________________ GROUP# ____________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ____ YES ____ NO **IF YES, COMPLETE THE FOLLOWING:**

FAMILY COVERAGE ____ OR SINGLE COVERAGE ____

POLICYHOLDER ____ RELATIONSHIP TO PATIENT ______________

POLICYHOLDER'S ADDRESS ____

BIRTHDATE ________ SOC. SEC. # __________________ NAME OF EMPLOYER __________________ WORK PHONE ____________

INSURANCE COMPANY ______________________________________ ID# ____________________________ GROUP# ____________

We ask that your fees be paid at each appointment. We accept cash, personal checks, money orders, VISA, MC. and Discover. Please advise our business staff if you would like to apply for outside financing. Charges not paid within 60 days will have a service charge of 1.5% per month (Annual Rate of 18%)

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SIGNATURE