

ATTENDING DR. \_\_\_\_\_

CHART NUMBER \_\_\_\_\_

PATIENT INFORMATION					
PATIENT			STREET ADDRESS		
CITY & STATE		ZIP CODE	HOME PHONE #	BUSINESS PHONE #	
WHO REFERRED YOU TO THIS OFFICE?		GENERAL DENTIST		HOW LONG HAVE YOU BEEN A PATIENT OF GENERAL DDS?	
SOCIAL SECURITY #		DATE OF BIRTH	AGE	GENDER: FEMALE	MALE
				<input type="checkbox"/>	<input type="checkbox"/>
EMPLOYER	EMPLOYER STREET ADDRESS / CITY / STATE / ZIP			OCCUPATION	

PRIMARY DENTAL INSURANCE – SUBSCRIBER / CARDHOLDER INFORMATION					
SUBSCRIBER'S NAME			SOCIAL SECURITY #		
STREET ADDRESS/ CITY / STATE / ZIP – (IF DIFFERENT THAN ABOVE)				HOME PHONE	
SUBSCRIBER'S DATE OF BIRTH	IS THE PATIENT THE:		SUBSCRIBER'S EMPLOYER		
	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> SUBSCRIBER <input type="checkbox"/> DEPENDENT			
EMPLOYER ADDRESS/ CITY / STATE / ZIP		WORK PHONE	OCCUPATION	SUBSCRIBER IS:	
				<input type="checkbox"/> HOURLY	<input type="checkbox"/> SALARY
INSURANCE COMPANY		GROUP #	% COVERAGE	<input type="checkbox"/> RETIRED	

SECONDARY DENTAL INSURANCE – SUBSCRIBER / CARDHOLDER INFORMATION					
SUBSCRIBER'S NAME			SOCIAL SECURITY #		
STREET ADDRESS/ CITY / STATE / ZIP – (IF DIFFERENT THAN ABOVE)				HOME PHONE	
SUBSCRIBER'S DATE OF BIRTH	IS THE PATIENT THE:		SUBSCRIBER'S EMPLOYER		
	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> SUBSCRIBER <input type="checkbox"/> DEPENDENT			
EMPLOYER ADDRESS/ CITY / STATE / ZIP		WORK PHONE	OCCUPATION	SUBSCRIBER IS:	
				<input type="checkbox"/> HOURLY	<input type="checkbox"/> SALARY
INSURANCE COMPANY		GROUP #	% COVERAGE	<input type="checkbox"/> RETIRED	

**WE WILL SUBMIT YOUR INSURANCE FORMS FOR YOU. HOWEVER, WE DO NOT KNOW IF THEY WILL PAY ANY OF THE CLAIM. IF THE INSURANCE COMPANY DOES NOT PAY WHAT IS ANTICIPATED, THE PATIENT / GUARDIAN REMAINS RESPONSIBLE FOR THE BALANCE.**

Because of the nature of referral work, we must respectfully request that all patient balances be paid upon completion. If unable to do so, please advise us now. Time payments are available only through MasterCard, Visa, Discover Card, Amex or Care Credit.

Charges not paid within 30 days will have a service charge of 0.58% per month (Annual rate of 7%) added to the past due balance on each monthly statement thereafter.

Our usual and customary fee schedule on file with dental insurance companies, State of Michigan:

Consultation and Exam ..... 90.00	Surgical Biopsy Removal..... 375.00
Anterior Root Canal ..... 845.00	Incision & Drainage ..... 125.00
Bicuspid Root Canal ..... 975.00	First Film ..... 30.00
Molar Root Canal ..... 1110.00	Each Additional Film ..... 26.00
Retreat Anterior Root Canal ..... 1070.00	Pulp Testing ..... 55.00
Retreat Bicuspid Root Canal ..... 1200.00	Bleaching ..... 300.00
Retreat Molar Root Canal ..... 1335.00	Nitrous Oxide ..... 75.00
Surgery (including retrograde fill) ..... 1410.00	Emergency Treatment Only ..... 300.00

I, the undersigned, being the patient, parent or guardian state the above information is true to the best of my knowledge and understand that I am ultimately responsible for any charges incurred. I authorize release of any information relating to this claim. I hereby authorize payment directly to the attending dentist of the group insurance benefits otherwise payable to me.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE