PATIENT INFORMATION FORM

Last Name:_________________________ **First Name:**___________________ **MI:** ________

Address: Street ____ Apt. ______________

City: _______________________State: _________ Zip Code:____________

SSN #: ___/___/____ **Male Female DOB:** ___/ ___ / ____ **Marital Status: M S D W**

Home Phone: ___________________**Cell:**__________________ **Work:** _______________

Email Address: ________________________________@____________________

Please tell us how you heard of our office: ______________________________

What is the number ONE concern about the appearance of your teeth? _________________

Emergency Contact: __________________ **Phone #:**____________**Relation:** ____________

Do you have any special requests regarding your dental treatment? ____________________

PRIMARY INSURANCE COVERAGE

Subscriber's Name and Address: ____

Subscriber's Relation to Patient: __________Sub.'s Soc. Sec.#(**nec**) ____ - ___- _____

DOB: ____ /___ /______ Employer: ________________________________

Insurance Company Name: _________________________________ Group #: ________

Employer: _______________________________

Patient/Account Agreement

I have dental insurance coverage with________________, and I assign all benefits to Dr. Schuck/Great smiles of Hicksville, if any, otherwise payable to me for all services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by my insurance company, including deductibles, co-payments and non-covered services. Interest of **2.0%** per month (24% annually) or a billing charge will be charged to overdue accounts after 60 days. **We reserve the right to charge $150.00 per hour for appointments cancelled without 24-hour notice**. I hereby authorize the release of all necessary information and documents (x-rays, etc.) to secure payment of benefits. Any collection costs (including ***all*** court & attorney's fees) will be charged to delinquent accounts, and ***will*** be reported to credit rating agencies. I am responsible to verify my own insurance coverage and know my insurance benefits and do not hold
Great Smiles of Hicksville responsible for this information. *I realize that insurance assignment is a courtesy extended by Family Dental and that I am ultimately responsible for payment of all services rendered even if the insurance company denies payment for any reason to this office.*

Account Holder's Signature: ___________________________________Date: / /