I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer. X Patient or Responsible Party □ Payment in full at each appointment (□VISA □MC □OTHER Card # □ Exp. Date □ I wish to discuss the Dental Office's Financial Policy SERVICE CHARGE If I do not pay the entire new balance within □ days of the monthly billing date, a service charge will be added to the account for the currer monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period. The service charge will be a periodic rate of □ monthly billing period	PATIENT INFORMATION					DATE		
ADDRESS STREET APT.# OITY STATE ZP BIRTHDATE	NAME	==-3			☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE		FEMALE	
ADDRESS STREET	LAST		FIRST	М				
BIRTHDATE MONTH DAY YEAR TELEPHONE	SOCIAL SECURITY #							
BIRTHDATE MONTH DAY YEAR TELEPHONE HOME WORK CELL EMAIL. ADDRESS GRADE PERSON RESPONSIBLE FOR ACCOUNT PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER MINDIO CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PAREET REFORMATION DALES - COMPLETE FEMANY RISURED DALE CORRESS - COMPLETE FOR RESPONSIBLE PARTY BETHEATE OITY STATE ZP STREET DITY STATE ZP ZP STREET DITY STATE ZP	ADDRESS							
NAME OF EMPLOYER	V de Antalataria managaria	STREET	APT,#	CITY	STA	TE Z	NP .	
NAME OF EMPLOYER	BIRTHDATE	AY YEAR	The second second	ME	WORK	CELL	F-MAII	
PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER INSURANCE INFORMATION DALTA-COMPLET PRIVATE BOTH BLOCKS FOR PARENT INFORMATION DOLL COVERAGE? ALSO COMPLETE SCONDARY INSURED PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY LAST FIRST M STREET CITY STATE ZP THOME WORK CEIL E-MAIL BIRTHOATE (MODAYYEAR) RELATIONSHIP TO PATIENT BIRTHOATE (NAME OF EMPLOYER				11.000 TABLE 12.000			
INSURANCE INFORMATION AND RESED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION ADJUGATED BOTH BLOCKS FOR PARENT INFORMATION BURDED BOTH B	IF FULL TIME STUDENT, SCH		GRADE					
PRIMARY INSURED IF NO INSURANCE COMPLETE SECONDARY INSURED	PERSON RESPONSIBLE FOR	RACCOUNT - PLE	EASE CHECK ON	E: PATIENT	□GUARDIAN □S	POUSE FATHER	MOTHER	
LAST FIRST M STREET CITY STATE 2P HOME WORK CELL E-MAIL BIRTHDATE (MODAY/YEAR) RELATIONSHIP TO PATIENT EMPLOYER DENTAL INS. CO SS# SUBSCRIBER# GROUP# PERSON TO CONTACT IN CASE OF EMERGENCY Name Address City/State/ZIP Telephone # AUTHORIZATION I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and the rapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories and other information about my dental reteatment to third party payors and/or other health professionals by any membod, including electronic transfer. X Patient or Responsible Party Patient or Responsible Party LAST FIRST M MEMAIL HOME WORK CELL E-MAIL BIRTHDATE (MODAY/YEAR) RELATIONSHIPTO PATIENT BIRTHDATE (MODAY/YEAR) RELATIONSHIPTO PATIENT BIRTHDATE (MODAY/YEAR) RELATIONSHIPTO PATIENT EMPLOYER BIRTHDATE (MODAY/YEAR) RELATIONSHIPTO PATIENT BIRTHDATE (MODAY/YEAR) RELATIONSHIPTO PATIENT BIRTHDATE (MODAY/YEAR) RELATIONSHIPTO PATIENT BIRTHDATE (MODAY/YEAR) RELATIONSHIPTO PATIENT EMPLOYER BIRTHDATE (MODAY/YEAR) RELATIONSHIPTO PATIENT BIRTHDATE (MODAY/YEAR) RELATIONSHIPTON TO PA	INSURANCE INFORMATIO	N ADULTS - C	COMPLETE PRIMARY IN:	SURED		RMATION		
STREET CITY STATE ZP HOME WORK CELL E-MAIL BIRTHDATE (MODAY/YEAR) RELATIONSHIP TO PATIENT EMPLOYER DENTAL INS. CO SS# SUBSCRIBER # GROUP # Has any member of your family ever been treated in our office? Whom may we thank for referring you to our office? Whom may we thank for referring you to our office? Whom may we thank for referring you to our office? Whom may we thank for referring you to our office? Whom may we thank for referring you to our office? Whom may we thank for referring you to our office? Whom may we thank for referring you to our office? Whom may we thank for referring you to our office? WETHOD OF PAYMENT Responsible party currently has an account with this office yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (CVISA MC OTHER Card # Exp. Date I wish to discuss the Dental Office's Financial Policy SERVICE CHARGE If I do not pay the entire new balance within days of the month billing date, a service charge will be a periodic rate of yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$ yer month (or a minimum charge of \$ for a balance under \$	PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY			SECONDARY INSURED				
HOME WORK CELL E-MAIL BIRTHDATE (MODAY/YEAR) RELATIONSHIPTO PATIENT EMPLOYER DENTAL INS.CO SS# SUBSCRIBER# GROUP# Has any member of your family ever been treated in our office? Whom may we thank for referring you to our office? Whom may we thank for referring you to our office? Whom may we thank for referring you to our office? WHOME THOD OF PAYMENT Responsible party currently has an account with this office Yes No Whom may we thank for referring you to our office? METHOD OF PAYMENT Responsible party currently has an account with this office Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (VISA MC OTHER Card # Exp. Date I wish to discuss the Dental Office's Financial Policy SERVICE CHARGE If do not pay the entire new balance within days of the month billing date, a service charge will be added to the account for the currer monthy billing period. The service charge will be aperiodic rate of per month (or a minimum charge of \$ for a balance und service that of the service charge will be added to the account for the currer monthy billing period. The service charge will be aperiodic rate of per month (or a minimum charge of \$ for a balance und service charge will be added to the account for the currer monthy billing period. The service charge will be a deed to the account for the currer monthy billing period. The service charge will be a periodic rate of per month (or a minimum charge of \$ for a balance und service that the fair to refere the period. The service charge will be a periodic rate of per month (or a minimum charge of \$ for a balance und service that of the period the service charge will be added to the account for the currer monthy billing period. The service charge will be a periodic rate of per month (or a minimum charge of \$ for a balance und service that the part payors and/or other health professionals by any which is an annual percentage rate of \$ for a balance und service that of the periodic professionals account or the	LAST	FIRST	М	LAST		FIRST	м	
BIRTHDATE (MOIDAY/YEAR) RELATIONSHIP TO PATIENT EMPLOYER DENTAL INS. CO SS# SUBSCRIBER # GROUP # Has any member of your family ever been treated in our office? Yes No Whom may we thank for referring you to our office? WETHOD OF PAYMENT Responsible party currently has an account with this office Yes No METHOD OF PAYMENT Responsible party currently has an account with this office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer. X Patient or Responsible Party BIRTHDATE (MOIDAY/YEAR) RELATIONSHIP TO PATIENT BEMPLOYER DENTAL INS. CO SS# SUBSCRIBER # GROUP # WHOM may we thank for referring you to our office? WHOM may we thank for referring you to our office? WHOM may we thank for referring you to our office? Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) SERVICE CHARGE It do not pay the entire new balance within days of the month) billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of per month (or a minimum charge of § or a balance under the last month for a minimum charge of § or a balance under the last month for a minimum charge of § or a balance under the last month for a minimum charge of § or a balance under the last month for a minimum charge	STREET CITY	STATE	ZIP	STREET	CITY	STATE	ZIP	
PERSON TO CONTACT IN CASE OF EMERGENCY Name Address City/State/ZIP Telephone # AUTHORIZATION I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office of administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental treatment on this page and the dental treatment to third party payors and/or other health professionals by any method, including electronic transfer. X Patient or Responsible Party DENTAL INS.CO SS# SUBSCRIBER # GROUP # Has any member of your family ever been treated in our office? WETHOD OF PAYMENT Responsible party currently has an account with this office Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (VISA MC OTHER Card # Exp. Date I wish to discuss the Dental Office's Financial Policy SERVICE CHARGE If I do not pay the entire new balance within days of the monthly billing pariod. The service charge will be added to the account for the currer monthly billing pariod. The service charge will be added to the account for the currer monthly billing pariod. The service charge will be added to the account of the currer monthly billing pariod. The service charge will be added to the account for the currer monthly billing pariod. The service charge will be added to the account of the party part in the last month's billing pariod. The service charge will be added to the account of % applied the last month's billing pariod. The service of default of payment, I promise the pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.	HOME WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL	
PERSON TO CONTACT IN CASE OF EMERGENCY Name Address City/State/ZIP Telephone # AUTHORIZATION I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office of administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer. X Patient or Responsible Party SUBSCRIBER # GROUP # Has any member of your family ever been treated in our office? Whom may we thank for referring you to our office? METHOD OF PAYMENT Responsible party currently has an account with this office Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cylisa No Cothern Card #	BIRTHDATE (MO/DAY/YEAR)	RELATIONSHIP TO PA	TIENT	BIRTHDATE (M	O/DAY/YEAR)	RELATIONSHIP TO PAT	ENT	
Has any member of your family ever been treated in our office?	EMPLOYER DENTAL INS. CO			EMPLOYER	DENTAL INS. CO			
Yes No Whom may we thank for referring you to our office?	SS#	SUBSCRIBER#	GROUP#	SS#		SUBSCRIBER #	GROUP#	
Address City/State/ZIP Telephone # AUTHORIZATION I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer. X Patient or Responsible Party METHOD OF PAYMENT Responsible party currently has an account with this office Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (INTICATION INTICATION INTI	IN CASE OF EMERGENCY			□Yes	□No	Si Name w		
METHOD OF PAYMENT Responsible party currently has an account with this office Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (Cash or personal check) Payment in full at each appointment	Name					\$5.54		
AUTHORIZATION I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer. X Patient or Responsible Party Patient or Responsible Party Responsible party currently has an account with this office Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cylical party in full at each appo	Address			METH	OD OF PAYMEN	JT]		
AUTHORIZATION I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer. Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (cash or personal check) Payment in full at each appointment (author cach in full at each appointment (cash or personal check) Payment in full at each appointment (author cach in full at each	531/27 20 NS			Respor	nsible party currer	0/0	with this office	
Payment in full at each appointment (□VISA □MC □OTHER Card # □ Exp. Date □ I wish to discuss the Dental Office's Financial Policy Payment in full at each appointment (□VISA □MC □OTHER Card # □ Exp. Date □ I wish to discuss the Dental Office's Financial Policy SERVICE CHARGE If I do not pay the entire new balance within □ days of the monthly are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer. Payment in full at each appointment (□VISA □MC □OTHER Card # □ Exp. Date □ I wish to discuss the Dental Office's Financial Policy SERVICE CHARGE If I do not pay the entire new balance within □ days of the monthly billing date, a service charge will be added to the account for the currer monthly billing period. The service charge will be a periodic rate of □ 9 per month (or a minimum charge of \$ □ for a balance under the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.			☐ Payment in full at each appointment (cash or personal check)					
account or future outstanding accounts.	I hereby authorize payment direct insurance benefits otherwise payresponsible for all costs of dental tre Office to administer such medica photographic and therapeutic procedental care. The information on this pare correct to the best of my knowle release my dental/medical histories treatment to third party payors and method, including electronic transfix	able to me. I under latment. I hereby au- tions and perform dures as may be neo- page and the dental ladge. I grant the right and other information for other health pro-	rstand that I am thorize the Dental such diagnostic, cessary for proper /medical histories at to the dentist to n about my dental	Card # I wish SERVIC If I do not billing da monthly per mor s the last pay any	n to discuss the D CE CHARGE of pay the entire new ate, a service charge billing period. The ser th (or a minimum) which is an anr month's balance. In legal interest on the	Exp. Da ental Office's Finance v balance within e will be added to the ac vice charge will be a peri charge of \$ final percentage rate of the case of default of pi e balance due, togethe	days of the monthly count for the current odic rate of% or a balance under% applied to ayment, I promise to r with any collection	
	Patient or Responsible Party Date	State Driver's Line	inse #				ect collection of this	