THE DENTAL SPECIALTY CENTER
FALCON

PATIENT INFORMATION

DATE: _____

NAME: _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY ESTATE ZIP

BIRTHDATE _____ **TELEPHONE** _____
MONTH DAY YEAR HOME WORK CELL EMAIL

NAME OF EMPLOYER _____ **ADDRESS** _____

IF FULL TIME STUDENT, SCHOOL NAME _____ **GRADE** _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INJURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / **FOR RESPONSIBILITY PARTY IF NO INSURANCE COMPLETE**			
LAST	**FIRST**		**M**
STREET	**CITY**	**ESTATE**	**ZIP**
HOME	**WORK**	**CELL**	**EMAIL**
BIRTHDATE (MO/DAY/YEAR)		**RELATIONSHIP TO PATIENT**	
EMPLOYER		**DENTAL INS.CO**	
SS#	**SUBSCRIBER #**		**GROUP #**

SECONDARY INSURED			
LAST	**FIRST**		**M**
STREET	**CITY**	**ESTATE**	**ZIP**
HOME	**WORK**	**CELL**	**EMAIL**
BIRTHDATE (MO/DAY/YEAR)		**RELATIONSHIP TO PATIENT**	
EMPLOYER		**DENTAL INS.CO**	
SS#	**SUBSCRIBER #**		**GROUP #**

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Has any member of your family ever been treated in our office?
☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

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 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 health professionals by any method, including electronic transfer.

_____
Patient or Responsible Party

_____

SERVICES CHARGE

If you do not pay the entire new balance within 30 days of the monthly billing date, a service charge of $5.00, will be added to the account for the current monthly billing period. In the case of default of payment, you agree to pay any legal fees on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Date State Driver’s License#