Patient Information Form

Robert C. Doshier D.D.S. P.A.
Patient Information

You may print this form, fill out and bring with you to your appointment.

Patient Information

Name (Last, First, MI):

Check All That Apply:

☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female

Address:

City: State:

Zip:

Birthdate (Mo/Day/Year):

Home Phone: Work Phone:

Fax:

E-Mail:

Place of Employment:

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 insured

Dual Coverage - Also complete secondary insured

Primary Insured/If No Insurance Complete For Responsible Party

Last: First: MI:

Address: City:

State: Zip:

Home Phone: Work Phone:

Fax:

E-Mail:

Birthdate (Mo/Day/Year):

Relationship to Patient:

Employer:

Dental Insurance Co:

SS#:

Subscriber#: Group#:

Secondary Insured

Last: First: MI:

Address: City:

State: Zip:

Home Phone: Work Phone:

Fax:

E-Mail:

Birthdate (Mo/Day/Year):

Relationship to Patient:

Employer:

Dental Insurance Co:

SS#:

Subscriber#: Group#:

Person To Contact In Case Of Emergency (Outside of Immediate Family Household)

Name:

Address:

City: State:

Zip: Home Phone:

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.

Signature:

Patient or Responsible Party

Date: State Driver's License #:

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 Number: _____ 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 current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to 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.

Has any member of your family ever been treated in our office?

☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____