JOHN MINALT, D.D.S.

Patient: **(Dr., Master, Miss, Mr., Mrs., Ms.)** Date_____

First_____ MI_____ Last_____
Preferred Name:_____ Male_____ Female_____ DOB_____/_____/_____
Address_____ Apt #_____
E-Mail Address_____
City_____ State_____ Zip Code_____
Phone: Home # (_____)_____ Cell # (____)_____
Employer_____ Address_____
Work # (____)_____ SS#_____
Dentist_____Physician_____ Referred by_____

Have any family members or relatives been treated in our office? Please name:_____
_____

Guarantor (Person financially responsible for patient)

Patient relation to Guarantor:_____Self _____Spouse _____Child _____Parent _____Other
If other than self, please complete:
Guarantor (Dr., Master, Miss, Mr., Mrs., Ms.)_____
First Last
Address_____ Apt #_____
City_____ State_____ Zip Code_____
Phone: Home # (____)_____ Cell # (____)_____
Employer_____ Address_____
Work # (____)_____ SS#_____

Insured Party Information

Primary Insured Party Info (cardholder)

_____
First Last
Address_____
_____
City State Zip
Relation:____self ____spouse ____child ____other
SS#_____-_____-_____ ID#_____
DOB____/____/____ Male_____ Female_____

Primary Dental

Insurance Co._____
Address_____
Ins. Phone # (___)_____
Group #_____

Secondary Insured Party Info

_____
First Last
Address_____
_____
City State Zip
Relation:_____self____spouse____child____other
SS#_____-_____-_____ ID#_____
DOB____/____/____ Male_____ Female_____

Secondary Dental

Insurance Co._____
Address_____
Ins. Phone # (___)_____
Group #_____

PLEASE CONTINUE ON OTHER SIDE

It is the policy of our office that full payment is due at the time services are rendered. We accept MasterCard, Visa, and Discover, American Express cards, debit cards as well as cash and personal checks.

If a payment plan would be desirable to you, please let us know, as we do work with a company that provides interest-free financing for dental services.

As a courtesy to you, we will be happy to submit your claim to your insurance company. Please remember that insurance is considered a method of reimbursing the patient for fees charged to you by our office.

We welcome and encourage discussion of services and fees prior to treatment in order to avoid misunderstandings.

Also, as a courtesy to our office, if, for any reason you cannot keep your appointment, please call our office 48 hours in advance. There will be an $80 charge for a missed appointment.

If you have any questions, we will be happy to assist you.

My signature authorizes the release of information requested by the insurance company which is necessary to process my claim. I understand that I am financially responsible for all charges.

Signature:_____ Date:_____