Wallingford Dental Associates

PATIENT INFORMATION

Patient Name_____
Date of Birth_____Soc. Sec# _____
Address_____
City, State, Zip Code_____
Home Phone_____Cell Phone_____Work Phone _____
Email address _____
Driver's License (state and #) _____
Employer_____

How shall we contact you: _____Home Phone_____Cell Phone_____Work Phone_____Email
In case of emergency, who can we contact?(name and number)_____

SPOUSE OR PARENT/GUARDIAN INFORMATION

Name_____
Date of Birth_____Soc. Sec #_____
Employer_____

DENTAL INSURANCE INFORMATION

Primary Insurance_____
Group #_____ID#_____
Name of Insured_____Date of Birth_____
Employer_____
Employer Address_____
Relationship to Patient _____Self_____Spouse_____Parent/Guardian

Secondary Insurance_____
Group #_____ID#_____
Name of Insured_____Date of Birth_____
Employer_____
Employer Address_____
Relationship to Patient _____Self_____Spouse_____Parent/Guardian

FINANCIAL POLICY

Individual responsible for account balances_____
Relationship to Patient _____
Address_____Phone_____
City, State, Zip Code_____

Payment is expected at the time the work is completed. As a courtesy, we will submit claims on your behalf to the insurance company. Financial arrangements must be made on all unpaid balances. A 1.5% monthly interest (18% annually) will be added after 60 days to any unpaid balance. In the event of default, the patient and/or guardian is liable for all collection costs and reasonable attorney fees. We accept cash, check, credit cards and "Care Credit."

Signature of patient and/or guardian Date

PLEASE HAND INSURANCE CARD TO RECEPTIONIST