

**PATIENT INFORMATION**

Date: \_\_\_\_\_ Best # to contact during the day: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Home Work Cell E-Mail

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Whom may we thank for referring you to our office? : \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

PRIMARY INSURANCE:

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Last First M

Insured's Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Insured's Telephone: \_\_\_\_\_  
Home Work Cell

Insured's Employer: \_\_\_\_\_ Relationship to Patient : \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Insured's SSN#: \_\_\_\_\_ Grp #: \_\_\_\_\_

SECONDARY INSURANCE:

- Check this box if you have secondary dental insurance and complete the backside of this form.

EMERGENCY CONTACT: \_\_\_\_\_  
Name Relationship to Patient Daytime Phone #

I hereby authorize payment directly to Traverse Dental Associates, P.C. of the group insurance benefits otherwise payable to me, if allowed by my insurance carrier. I hereby authorize Traverse Dental Associates, P.C. 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 is 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. I understand that I am responsible for all costs of dental treatment and that full payment or my co-payment is due at each appointment. In the case of default of payment greater than 60 days, I promise to pay a service charge at a periodic rate of 1.5% per month, which is an annual percentage rate of 18% as well as 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.

X \_\_\_\_\_  
Patient's Signature

\_\_\_\_\_   
State Driver's License #

Date: \_\_\_\_\_

