

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment # City State Zip Code  
E-Mail Address: \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

## Employer Information

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_  Male  Female  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment # City State Zip Code

## Dental Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI  
Insured's Birthdate: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street City State Zip Code  
Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI  
Insured's Birthdate: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street City State Zip Code  
Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

## Policy of Care and Payment

### Initial

\_\_\_\_\_ **As a condition of your treatment plan by this office, financial arrangements must be made in advance.** Seattle Sound Dental requires payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, cash and check. If you are in need of an extended finance option, we also work with Care Credit, who offer finance free options designed to meet your treatment plan needs on approved credit.

### Initial

\_\_\_\_\_ **Insurance:** You are responsible for the entire balance of any treatment you receive. We will be glad to file your insurance electronically. Due to the large variety of insurance companies and plans, we are unable to determine the exact amount of coverage for each plan at the time of treatment. Your insurance coverage will be estimated and the remaining balance is due at time of treatment.

### Initial

\_\_\_\_\_ **Missed Appointment/Late Cancellation:** Please give us the courtesy of a 48 business hour notice if you are unable to make your appointment. If adequate notice is not given, a Missed appointment/Late Cancellation charge will be applied to your account in the amount of \$50.00 for each hour of time scheduled.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_