

# OAK CLIFF DENTAL CARE

4640 NICOLS ROAD • SUITE 100 • EAGAN, MINNESOTA 55122 • (651) 454-1414

## PERSONAL INFORMATION

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Preferred name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext. #: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

Male       Minor       Single       Married  
 Female

If Married, Name of Spouse: \_\_\_\_\_

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

If Full Time Student, School Name: \_\_\_\_\_

City, State: \_\_\_\_\_

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

Yes    No   Name: \_\_\_\_\_

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

In the event of an emergency, who should we contact?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext. #: \_\_\_\_\_

## SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

## 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 and therapeutic procedures as may be necessary for proper dental care for myself and/or my minor children. 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 payers and/or other health professionals.

X \_\_\_\_\_  
 Adult Patient    Father (Or Husband)    Mother (Or Wife)    Guardian

Date \_\_\_\_\_

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

## PERSON RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. #: \_\_\_\_\_

Home Phone: \_\_\_\_\_

## PRIMARY INSURANCE

Name of Insured: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Tele. # \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

## ADDITIONAL INSURANCE

Name of Insured: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Tele. # \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

## FAIL / CANCELLATIONS

We trust that you will be here for the time you have reserved with us. If you fail or cancel without a 24 hour notice, a fee will be charged to your account.

## METHOD OF PAYMENT

Payment in full of the estimated amount not covered by insurance

Payment in full at each appointment (cash or personal check)

Payment in full at each appointment ( VISA    MC)

Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Care Credit \_\_\_\_\_