JAMES STREET
DENTAL

22 James Street • Geneva, IL 60134 • 630-232-9535

# WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions, or need assistance, please ask us– we will be happy to help.

## PERSONAL INFORMATION

Date_____ Date of Birth:_____

SS#/ SIN_____ Email:_____

Name:_____

Wishes to be called_____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address_____

City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. #_____

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

Name _____ Relationship_____ Work #_____ Home #_____

Employer_____ Occupation_____

Referred by _____

## RESPONSIBLE PARTY

Who is responsible for the account?

Name_____

Relationship to Patient_____

Birthdate_____ SS#/ SIN_____

Email _____

Address_____

City_____ State_____ Zip_____

Employer_____ Occupation_____

Work Phone _____ Ext. #_____

Home Phone _____ Cell Phone _____

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## DENTAL INSURANCE INFORMATION

| Primary Insurance | Additional Insurance |
|---|---|
| Name of Insured_____ | Name of Insured_____ |
| Relationship to Patient_____ | Relationship to Patient_____ |
| Insured's Birthdate_____ | Insured's Birthdate _____ |
| SS#/SIN_____ | SS#/ SIN _____ |
| Employer_____ | Employer_____ |
| Date Employed_____ | Date Employed_____ |
| Occupation_____ | Occupation_____ |
| Insurance Company_____ | Insurance Company _____ |
| Group #_____ | Group #_____ |
| Employee/Cert #_____ | Employee/Cert #_____ |
| Ins. Co. Address_____ | Ins. Co. Address_____ |
| Deductible_____ | Deductible_____ |
| Amount already used_____ | Amount already used_____ |
| Max annual benefit_____ | Max annual benefit_____ |

## AUTHORIZATION and RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**X**_____

Signature of patient or parent/guardian if minor Date

## FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option you prefer.

* Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card _____ Visa _____MC

_____ I wish to discuss the dental office's policy

### Late Charges

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 when 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

**Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask– we are always happy to help.**