ARTISAN DENTAL
Cosmetic, Sedation and Implant Dentistry

Patient Information

Patient Name: _____ Date:_____
Last First MI

Gender (circle one): Male Female Other Marital Status (circle one): Married Single Other _____

Social Security #: _ _ _- _ _ - _ _ _ _ Birth Date: _ _- _ _ - _ _ DL#_____ Issuing State _____

Phone (Home): _____ (Work): _____ Ext: _____ (Mobile): _____

Email address: _____ May we contact you by email? ☐Yes ☐No

Address: _____
Street Unit or Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice?

☐Another Patient ☐Brochure ☐ZocDoc ☐Another Practice ☐Yelp ☐Google ☐Other

Name of person or office referring you to our practice:_____

Employment Information

The following is for: the patient or the person responsible for payment

Employer Name: _____Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

We will assist in your insurance processing

Primary

Name of Insured: _____ is insured a patient? ☐Yes ☐No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Social Security #: _____-_____-_____

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: _____

Consent for Services

Payments for dental treatment are due the time services rendered. Appointments cancelled with less than 48 hours' notice may incur a $50 fee. In addition to cash and checks, we accept Visa, MasterCard, Discover and AMEX. If you have dental insurance, it is our policy to help you receive the maximum benefits. As a courtesy to you, we will complete a claim form so that you can be reimbursed by your insurance company. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

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

_____ Date: _____ Relationship to Patient:
Signature of guarantor of payment/responsible party