WELCOME

Patient Name:____

Date of Birth:______________________ □Male□Female

Address:____

City________________________State________________Zip__________

Daytime Phone:____________ Evening Phone:____________ Cell:_____________

Email:________________________________

Emergency Contact:___________________________Phone:____________________

****Whom May We Thank For Referring You?: _______________________________**

Responsible Party:________________________ Relationship to Patient:__________

Primary Insurance: ____
Relationship to insured:____
Insured Name:____________________________Date Birth:_____________________
Group #:_________________________Subscriber Id:___________________________

Secondary Insurance:____
Relationship to insured:____
Insured Name:_________________________________Date Birth:________________
Group #:_________________________Subscriber Id:___________________________

- I understand that Henrickson Dental will bill my dental insurance provider on my behalf and I authorize payment directly to Henrickson Dental otherwise payable to me. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts regardless of estimated insurance benefits.
- A finance charge of 18% annually will be charged on all accounts exceeding 60 days.
- I understand that my payment is due at the time services are rendered and agree to pay reasonable collection and/or attorney fees should my account default.

Signature of Patient, Parent or Guardian Date