PM Dental

20800 N. John Pkwy Ste. 105
Maricopa, AZ 85139

PATIENT INFORMATION

NAME ______________________________ ❑ MARRIED ❑ SINGLE ❑ MINOR ❑ MALE ❑ FEMALE
LAST FIRST M

SS # ______________________________ BIRTHDATE ______________________________
MONTH DAY YEAR

ADDRESS ____
STREET APT. # CITY STATE ZIP

TELEPHONE (HOME) ______________________ PLACE OF EMPLOYMENT ______________________
(WORK) ______________________ ADDRESS ______________________
(CELL) ______________________ ______________________

EMAIL ADDRESS ____

IF FULL TIME STUDENT, SCHOOL NAME ______________________________ GRADE ______________

PERSON RESPONSIBLE FOR ACCOUNT - CHECK ONE: ❑ PATIENT ❑ GUARDIAN ❑ SPOUSE ❑ FATHER ❑MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPETE PRIMARY INSURED
DUAL COVERAGE - ALSO COMPETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPETE FOR RESPONSIBLE PARTY	**SECONDARY INSURED**
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME # WORK # FAX #	HOME # WORK # FAX #
BIRTHDATE (MM/DD/YYYY) RELATIONSHIP TO PATIENT	BIRTHDATE (MM/DD/YYYY) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO.	EMPLOYER DENTAL INS. CO.
SS# SUBSCRIBER # GROUP #	SS# SUBSCRIBER # GROUP #

EMERGENCY CONTACT

*Outside of immediate Family Household

NAME ______________________________
ADDRESS ______________________________
CITY/STATE/ZIP ______________________________
TELEPHONE ______________________________

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 cost and dental treatment. I hereby authorize PM Dental to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge. I grant the right to the dentist to release my medical/dental histories and other information about my dental treatment to third party payors and/or other health professionals.

X ______________________________
Patient or Responsible Party

REFERRAL SOURCE

How did you hear about our office? (Please specify)

____

METHOD OF PAYMENT

Responsible party currently has an account with this office? ❑ Yes ❑ No

❑Payment in full at each appointment (CASH)

❑Payment in full at each appointment (VISA MC OTHER)

Card # ______________________________ Exp Date _______

❑I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE - If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of ____% per month (or a minimum charge of $______ for a balance under $_____) which is an annual percentage rate of ____% applied to the last month's balance. In the case of default payment, I promise to pay any legal interest on the balance.