

Patient Information

Date	How does the patient wish to be Addressed?	Who may we thank for referring you to our office?		
Payment Information		Email Address:		
Name of Primary Subscriber (Last, First, M.I.)		Insurance Plan	SSN	
Employer	Group #	Ins. Phone #	DOB	
Patient Information				
Name (Last, First, M.I.)		Home Phone		Alternative Phone
Home Street Address		City	State	Zip
		DOB		SSN
Employer/School	Position/Department	Relationship to Party		Gender M / F
Parent/Spouse/Guardian				
Name (Last, First, M.I.)		Home Phone		Alternative Phone
Home Street Address		City	State	Zip
		DOB		SSN
Employer	Position/Department			
Emergency Contact				
Name	Relationship	Phone	Family Members treated in office	
<p>Dear Patient:</p> <p>Full payments for services, along with co-payments are due and payable on the day of your dental visit. Your payment can be made by cash, check, credit card or financing through Care Credit. This is a non-billing office. For our preferred insurance carriers, the office of Dr. Gene Allen will complete and file your claim forms. Please note that if payment is not received within 45 days, you will be responsible for full payment of the account. Please understand that your dental healthcare plan is a contract between you, your employer, and your insurance company and not all services are a covered benefit under some contract agreements. You, as the patient, will be financially responsible for any charges not paid by your insurance company. A 24 hour cancellation notice is required if you must cancel an appointment or a charge will be applied.</p>		<p>Release:</p> <p>I authorize the dentist to perform diagnostic procedures and treatment as necessary for proper dental care. I authorize the release of any information concerning myself or my child's healthcare, advice, and treatment provided for the purpose of evaluation and administering claims for insurance benefits or to another dentist. I hereby authorize the assignment of benefits and payment to the office of Dr. Gene Allen. D.D.S</p> <p>X _____</p> <p>By signing my name to this document, I agree to accept financial responsibility for any dental services not covered by my insurance. I acknowledge and understand your office may charge 1.5% interest per month on all unpaid past due balances, plus any court/policy costs, and retrieval of credit reports when necessary.</p>		
Patient / Parent Signature _____ Date _____				