# Pinter Family Dental

**PATIENT**: First Name_____MI_____Last Name_____

Address _____City_____State_____Zip_____

Cell Phone#_____Home Phone#_____

Employer_____Occupation_____

Email_____Sex o M o F Date of Birth_____Age_____

Marital Status o Single o Married o Divorced o Widowed Spouse_____

Emergency Contact _____Phone#_____

Referred by_____

Who is Responsible for Account if different from above?_____

**Primary Dental Insurance Company**

Dental Ins. Co. Name_____

Address_____

SS#/ID#_____

Group#_____

Subscriber Name_____

Subscriber Address_____

Subscriber Cell Phone#_____

Subscriber DOB_____

Subscriber Employer_____

**Secondary Dental Insurance Company** **(Leave blank if N/A)**

Dental Ins. Co. Name_____

Address_____

SS#/ID#_____

Group#_____

Subscriber Name_____

Subscriber Address_____

Subscriber Cell Phone#_____

Subscriber DOB_____

Subscriber Employer_____

**Office Guidelines & Policies**

**Payment due at time of service**. Payment of your deductible and copay is due at each visit. We accept cash, checks and for your convenience - Visa, MasterCard, Discover & American Express. Any portion of Non-covered services by your insurance company is the patients responsibility. All balances past due 30 days will be subject to a Monthly 1.5% fee.

**Cancelled & Missed Appointments**. Your appointment time has been reserved especially for you. Missed appointments or Cancellations without 48 hours notice will be subject to a broken appointment charge. Multiple missed appointments may be subject to dismissal from our practice.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date