



Family Account Information

Patient's Names:	Date of Birth:	Gender:
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

Date: _____

Name of Financially Responsible Person: _____
Last First MI

Social Security Number (Required): _____

Date of Birth: _____

Gender: Male Female **Family Status:** Married Single Divorced Other

Address: _____
Street City State Zip Code

Phone Numbers **May we leave messages regarding treatment, appointments or billing at these numbers?**

Home:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cell:	<input type="checkbox"/> Yes <input type="checkbox"/> No Text? <input type="checkbox"/> Yes <input type="checkbox"/> No
Work: ext:	<input type="checkbox"/> Yes <input type="checkbox"/> No

I understand that I am responsible for the cost of all dental treatment. I also understand that I am responsible for paying any copayments or deductibles that the insurance does not cover. I understand that I will be responsible for any fees if 3rd party collection efforts are required to collect a balance and for any returned check fees. I also understand that there will be a charge for any missed appointments or appointments cancelled with less than 24 hours notice to Dental Associates of Walpole.

Signature of Person Financially Responsible: _____ **Date:** _____

Insurance Information:

Policy Holder's Name: _____ **Date of Birth** _____
Last First MI

Subscriber ID #: _____ **Group #:** _____

Employer: _____

Name of Insurance Company: _____

I hereby authorize release of any information including diagnosis and records of treatment or examination to my insurance company.

Signature: _____ **Date:** _____