Robert D. Arnold, D.M.D.

PATIENT INFORMATION FORM

Date: ______________

Patient's Name: ______________________________
LAST FIRST MIDDLE

Home Address: ______________________________
STREET CITY STATE ZIP

Mobile Telephone Number: ( ) - ______________ Sex: ☐ Male ☐ Female

Email Address: ______________________________

Birthdate: / / ______________ Age: ______________
MONTH DAY YEAR

Social Security Number (SSN): - - ______________

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child

EMPLOYMENT INFORMATION

Employer: ______________ Occupation: ______________

Business Address: ______________________________
STREET CITY STATE ZIP

Business Telephone Number: ( ) - ______________ Extension: ______________

PARENT/GUARDIAN/SPOUSE INFORMATION

Father's Name:
(if patient is under 18) ______________________________
LAST FIRST MIDDLE

Mobile Telephone Number: ( ) - ______________ SSN: ______________

Employer: ______________ Occupation: ______________

Business Address: ______________________________
STREET CITY STATE ZIP

Dental Insurance: ☐ Yes ☐ No Ins. Company Name: ______________

Mother's Name:
(if patient is under 18) ______________________________
LAST FIRST MIDDLE

Mobile Telephone Number: ( ) - ______________ SSN: ______________

Employer: ______________ Occupation: ______________

Business Address: ______________________________
STREET CITY STATE ZIP

Dental Insurance: ☐ Yes ☐ No Ins. Company Name: ______________

Spouse's Name: ______________________________
LAST FIRST MIDDLE

Mobile Telephone Number: ( ) - ______________ SSN: ______________

Employer: ______________ Occupation: ______________

Business Address: ______________________________
STREET CITY STATE ZIP

Dental Insurance: ☐ Yes ☐ No Ins. Company Name: ______________

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INSURANCE INFORMATION

If there are two or more Insurance Companies, who has primary coverage? ____________________

Insured's DOB: ______ / ______ / ______
MONTH DAY YEAR

Insured's ID Number: ____________________ Group Number: ____________________

Secondary Insured's DOB: ______ / ______ / ______
MONTH DAY YEAR

Secondary Insured's ID Number: ____________________ Group Number: ____________________

Name of Person Responsible for Payment: ____________________
LAST FIRST MIDDLE

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

INSURANCE AUTHORIZATION

I hereby authorize payment directly to the provider of service for the claimed expenses as provided. I understand that I am financially responsible for charges not covered by my plan.

Signature: ____________________ Date: ____________

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?
☐ Another patient, friend ☐ Work ☐ Yellow Pages ☐ Other
☐ Another patient, relative ☐ School ☐ Newspaper

Name of person or office referring you to our practice: ____________________

EMERGENCY CONTACT INFORMATION

Contact's Name: ____________________
LAST FIRST MIDDLE

Phone Number: ( ) -

Relationship to Patient: ____________________

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patient's insurance forms and assist in making collections from insurance companies, and it will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered by me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered or credit is extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

Signature: ____________________ Date: ____________