

# Welcome

We are pleased to welcome you to Cowlitz River Dental. Please fill out this form as completely as possible. If you have questions, we'll be glad to help you.

DATE \_\_\_\_\_

NAME \_\_\_\_\_  MARRIED  SINGLE  MINOR  MALE  FEMALE  
LAST FIRST M

ADDRESS \_\_\_\_\_  
STREET APT.# CITY STATE ZIP

BIRTHDATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
MONTH DAY YEAR HOME# WORK# FAX# E-MAIL

PLACE OF EMPLOYMENT \_\_\_\_\_ SS# \_\_\_\_\_

IF FULL TIME STUDENT, SCHOOL NAME \_\_\_\_\_ GRADE \_\_\_\_\_

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME #	WORK#	FAX#	E-MAIL#	HOME #	WORK#	FAX#	E-MAIL#
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

### PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family Household  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/ZIP \_\_\_\_\_  
Telephone # \_\_\_\_\_

Has any member of your family ever been treated in our office?  
 Yes  No  
Whom may we thank for referring you to our office?  
\_\_\_\_\_

### METHOD OF PAYMENT

Responsible party currently has an account with this office  
 Yes  No  
 Payment in full at each appointment (cash or personal check)  
 Payment in full at each appointment ( VISA  MC  OTHER)  
Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_  
 I wish to discuss the Dental Office's Financial Policy

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

X \_\_\_\_\_  
Patient or Responsible Party  
\_\_\_\_\_  
Date

**SERVICE CHARGE**  
If I do not pay the entire new balance within 25 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 1.5% per month (or a minimum charge of \$3.00 for a balance under \$200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.