PATIENT INFORMATION FORM

O'Hara DENTISTRY

Name_____
(First) (Middle) (Last) (Nickname)
Home Address_____
City_____ State_____ Zip_____
Home Telephone No._____ Work Telephone No._____
Cell Phone No._____ E-Mail Address_____
Social Security #_____ Employer _____
Age_____ Birth Date _____ Male ☐ Female ☐ Height_____Weight_____
Single ☐ Married ☐ Divorced ☐ Widow Referred By_____

In case of emergency, who may we contact?

His/her Name_____ Relationship_____
Home Telephone No._____ Work Telephone_____

Person responsible for this account if other than yourself

His/her Name_____ Relationship_____
Billing Address_____
Home Telephone No._____ Work Telephone No._____
Employer_____ Social Security No._____

Dental Insurance Information

Primary Dental Insurance:
Insured's Name_____ Relationship_____
Address_____ Telephone No._____
Insurance Co. Name_____ Group No._____
Insured's Social Security or ID # _____
Insured's Date of Birth_____ Insured's Employer_____

Secondary Dental Insurance:
Insured's Name_____ Relationship_____
Address_____ Telephone No._____
Insurance Co. Name_____ Group No._____
Insured's Social Security or ID # _____
Insured's Date of Birth_____ Insured's Employer_____

I hereby authorize release of any information and records of treatment to my insurance company. I hereby authorize payment directly to the dental office for any services rendered.
I accept responsibility for payment of all charges. I understand that should my account become delinquent and is referred to an attorney for collection, I will be responsible for all costs of collection and attorney's fees of 33 1/3% of the unpaid balance at the time of referral. I accept incurring a $5.00 rebilling fee for each month my account remains unpaid for 90 days or over.