Welcome to Menomonie Street Dental

Patient Information

Today's Date: ____/____/_____

Patient's Name: _____

Preferred Name: _____ ☐ Male ☐ Female

Birthdate: ____/____/_____ Age: _____

Address: _____

City _____ State ____ Zip _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Email Address: _____

Referred By: _____

Employer: _____ How Long? _____

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How many? _____

Dental Insurance Information

Primary Dental Insurance:

Employee Name: _____

Employer: _____

Date of Birth ___/___/____ Relationship: _____

Insurance Company: _____

Phone #: _____

Insured SS# or ID#: _____ Gr #_____

Other covered dependents: _____

_____

Secondary Dental Insurance:

Employee Name: _____

Employer: _____

Date of Birth ___/___/____ Relationship: _____

Insurance Company: _____

Phone #: _____

Insured SS# or ID#: _____ Gr #_____

Other covered dependents: _____

_____

Responsible Party Information

Name: _____

Relationship to Patient: _____

Billing Address: _____

City _____ State ____ Zip _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Emergency Contact Information

Whom shall we contact? _____

Relationship: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Who is your Medical Doctor? _____

Medical Dr's Phone #: _____

Please read and initial the following statements:

_____ *I acknowledge that the above information has been completed to the best of my knowledge and will inform Menomonie Street Dental of any changes.*

_____*I authorize assignment of my insurance rights and benefits directly to Menomonie Street Dental and I assume full financial responsibility for all balances not paid by my insurance.*

_____ *I understand Menomonie Street Dental requires payment in full on the day of service for all services rendered, unless other financial arrangements have been made with a Treatment Coordinator. If account is not paid in full within 60 days of treatment, finance charges will apply. If not paid in full within 90 days and no financial arrangement has been made, you will be responsible for all legal fees and collection fees incurred in collecting your account.*

Signature: _____ *Relationship to Patient:* _____ *Date:* ___/___/____