Honolulu Smiles

DATE_____

PATIENT INFORMATION

NAME_____ [ ]Married [ ]Single [ ]Minor [ ]Male [ ]Female
Last First M

ADDRESS_____
Street Apt# City State Zip

BIRTHDAY_____ TELEPHONE_____
Month Day Year Home # Work # Fax # E-mail

PLACE OF EMPLOYMENT_____SS #_____

IF FULL TIME STUDENT, SCHOOL NAME_____GRADE_____

PERSON RESPONSIBLE FOR ACCOUNT- PLEASE CHECK ONE: [ ] Patient [ ]Guardian [ ]Spouse [ ]Father [ ]Mother

INSURANCE INFORMATION

Minor child- May need to complete both blocks for parent information
Adult- Complete Primary Insured. Dual coverage? Also complete Secondary Insured

PRIMARY INSURED / If no insurance complete for responsible party	**SECONDARY INSURED** / If no insurance complete for responsible party
Last Name First Name M	Last Name First Name M
Street City State Zip	Street City State Zip
Home # Work # Fax # E-mail	Home # Work # Fax # E-mail
Birth date (Mo/Day/Year) Relationship to Patient	Birth date (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_____

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 State Driver's License

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

- θ Payment in full at each appointment (cash or personal check)
- θ Payment in full at each appointment [ ] VISA [ ] MC [ ] Other

Card #_____Exp. Date_____

- θ I wish to discuss the Dental Office's Financial Policy

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.