

Gainseville Family Dentistry P.L.C.
14535 John Marshall Highway, Gainesville, VA (571) 261-2330

PATIENT INFORMATION

Full Name: _____ Male/Female
Birthdate: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Social Security #: _____
Employer: _____
Work Phone #: _____
Address: _____
C/S/Zip: _____

SPOUSE INFORMATION

Full Name: _____
Birthdate: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Social Security #: _____
Employer: _____
Work Phone #: _____
Address: _____
C/S/Zip: _____

GUARANTOR'S INFORMATION (if different from patient)

Full Name: _____ Birthdate: _____
Relationship: _____
Address: _____
Home Phone #: _____
City/State/Zip: _____
Social Security #: _____
Employer: _____
Work Phone #: _____
Address: _____
C/S/Zip: _____

INSURANCE INFORMATION

Primary Carrier

Insurance Co. _____
Address: _____
Phone #: _____
City/State/Zip: _____
Policy Holder/Subscriber: _____
Birth Date: _____
Social Security #: _____
Subscriber #: _____
Group #: _____

Secondary Carrier

Insurance Co. _____
Address: _____
Phone #: _____
City/State/Zip: _____
Policy Holder/Subscriber: _____
Birth Date: _____
Social Security #: _____
Subscriber #: _____
Group #: _____
Contract #: _____

OTHER INFORMATION

How were you referred to our office? _____
Relative not living with you to contact in case of an emergency: _____
Address: _____
Home Phone #: _____
City/State/Zip: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of and agree to pay all fees and charges for such treatment promptly upon presentment thereof. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of pendency of claims thereof. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.

If my account becomes assigned to a collection agency, I agree to pay all costs of collection, including 25% agency fees, court cost and attorney fees. I understand that all accounts with a balance over 60 days will be assessed a 1.5% [one point five percent] late charge per month on the unpaid monthly balance.

SIGNED: _____

DATED: _____