WELCOME TO GATEWAY DENTAL GROUP

Male / Female **Single / Married / Divorced**

Name____**Birth Date**______________**Driver's License #:** ________________
(First) *(Last)*

Address ____ **City** __________________________ **Zipcode** ____________

Home #:_________________________ **Work #:** ___________________**Ext.** _____ **Cellular #:** ________________________

Employer______________________________**Occupation**____________________**SocialSecurity #:** ___________________

Email address:____

Dental Coverage Y / N Dental Insurance Co. ________________________**Phone #:**_______________**Group #:**________

Whom may we thank for referring you? ____

Spouse Name_______________________________**Birth Date**______________ **Spouse Social Security #:**_______________

Spouse Employer ____________________________**Occupation**____________________**Wk #:**_________________**Ext.**____

Name of child________________________________**Birthday**______________________**Last visit to dentist**_____________

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Name of child________________________________**Birthday**______________________**Last visit to dentist**_____________

Comments if applicable:____

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Dental Coverage Y / N Dental Ins. Co. ________________________**Phone #:**___________________**Group #:** __________

Who is responsible for this account? ___________________________________**Relationship to patient** ________________

S/S #:___________________________ **D/L #:** _________________**Phone #:**____________________

In case of an emergency, who should be notified? ______________________________**Phone #:** _______________________

Is there anything about your smile you would like to change or improve? ____

What can we do for you to make your dental visits as pleasant as possible? ____

When was your last dental check up and cleaning?____

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement of the patient's financial responsibility at the time of service. Patients with insurance coverage must pay at the time of service any and all co-pays, deductibles, out-of-pocket cost. Gateway Dental Group will process the necessary insurance claims and accept insurance reimbursements, but ultimately the patient is directly responsible for the reimbursement of all dental services. ________**(Initial)** A service charge of 1.5% per month (18% annually)on the unpaid balance will be charged on all accounts exceeding 30 days, unless prior written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of 6 months from the patient examination date__________**(Initial).** **I hereby authorize payment of dental benefits otherwise payable to me, directly to Gateway Dental Group, Shadi Rad, DDS, MS, for all claims or documents as related to any and all dental health benefits due me and my dependents through my employment.**

____ ______________ ________________________________
Signature of Patient or Parent /Guardian **Date** **Relationship to Patient**

____ ______________ ________________________________
Signature of Guarantor of Payment/Responsible Party **Date** **Relationship to Patient**