Confidential Patient Information for the Mount Hope Dentistry, LLC

Name: Mr. Mrs. Ms. Dr. _____ Nickname: _____
Address: _____ City_____State_____Zip _____
Home Phone: _____Work Phone: _____ Other: _____
Date of Birth: __/____/_____ SSN: _____
E-mail address: _____ Driver's License# _____ State _____
Are you a full-time student? Yes No Where? _____

Whom may we thank for referring you to our office?
Person to notify in case of an emergency: _____ Phone# _____

Will you be requiring credit (financing) by our office for dental care? Yes No
If yes, ask for a dental credit card application.

How will you be paying for the dental treatment? Please circle

1. Payment in full at time of appointment. (over $1,000.00-10% discount for cash or check.)
2. Credit Card: Visa, Master Card # _____Exp. Date _____
3. Monthly installments (I% interest per month after 90 days) with approved credit. Please speak with the front desk.

If you have Dental Insurance, please fill out below: We will gladly complete your dental insurance forms to help you receive the maximum benefit from your insurance company. Please bring in your insurance booklet so that we can keep it with your chart. Insurance is a contract between the insurance company and the patient, not the dentist. The patient is responsible for all charges of dental care and collection fees.

Name of person with insurance: _____Relationship: _____Employer:_____
Date of Birth:___/__/_____ SSN: _____
Primary: Insurance company name: _____Group# _____
Mailing address: _____Phone:_____
Deductibles: Individual $_____ Family $_____Maximum $ per year_____
Renewal Date: ___/__/_____

If you have dental insurance, please fill out below:

Name of person with insurance: _____Relationship: _____Employer:_____
Secondary: Insurance company name: Group# _____
Mailing address: Phone# _____
Deductibles: Individual $_____Family $ _____Maximum $ per year _____
Renewal Date:___/__/_____

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 and therapeutic procedures as may be necessary for proper dental care. The information on this page and on the medical history is correct to the best of my knowledge. And I also agree that if I **am financing,** I am giving permission to the permissible purpose rule, which allows a credit report to be run.

Signature _____ Date _____