

WELCOME

Patient Name: _____

Date of Birth: _____

Male Female

Address: _____

City _____ State _____ Zip _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

Email: _____

Emergency Contact: _____ Phone: _____

****Whom May We Thank For Referring You?:** _____

Responsible Party: _____ Relationship to Patient: _____

Primary Insurance: _____

Relationship to insured: _____

Insured Name: _____ Date Birth: _____

Group #: _____ Subscriber Id: _____

Secondary Insurance: _____

Relationship to insured: _____

Insured Name: _____ Date Birth: _____

Group #: _____ Subscriber Id: _____

- I understand that Twin Cities Modern Dentistry will bill my dental insurance provider on my behalf and I authorize payment directly to Twin Cities Modern Dentistry otherwise payable to me. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts regardless of estimated insurance benefits.
- A finance charge of 18% annually will be charged on all accounts exceeding 60 days.
- I understand that my payment is due at the time services are rendered and agree to pay reasonable collection and/or attorney fees should my account default.

Signature of Patient, Parent or Guardian

Date