Greg Moore DDS, PC FAGD

Cosmetic & Family Dentistry

Patient's First Name_____ M.I._____ Last Name_____

I prefer to be called_____ Student ___Single ___Married ___Widowed ___Other Birth Date_____

Social Security No._____ ___Male ___Female Driver's License #_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Employer_____ Work Phone_____

Prefer to be contacted via: ___Cell ___Text ___Email ___Home ___Work

Who may we thank for referring you to our office? _____

Person Financially Responsible for Account:

☐ SAME AS ABOVE

First Name_____ M.I._____ Last Name_____

Birth Date_____ Age_____ Social Security No._____ Relationship to pt._____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell phone_____ Email_____

Employer_____ Work Phone_____

Driver's License #_____

☐ NO DENTAL INSURANCE

Primary Insured	Secondary Insured
Subscriber Name_____	Subscriber Name_____
Subscriber SS#_____	Subscriber SS#_____
Date of Birth_____	Date of Birth_____
Relationship to Subscriber __Self __Spouse __Child __Other	Relationship to Subscriber __Self __Spouse __Child __Other
Employer Name_____	Employer Name_____
Employer Phone_____	Employer Phone_____
Insurance Company_____	Insurance Company_____
Insurance Group #_____	Insurance Group#_____
Insurance Phone #_____	Insurance Phone#_____

Emergency Contact Name_____ Relationship_____ Phone_____

PATIENT FINANCIAL RESPONSIBILITY: Payment for all services rendered is due in full at the time of visit, unless other prior arrangements have been made. Account balances not paid within 30 days will accrue interest at a rate of 1.5% per month. If account balance is not paid within 60 days of the date of service and no financial arrangements have been made, patient and/or guarantor will be responsible for, in addition to account balance, all costs of collection, including, but not limited to attorney's fees of no less than 25% of the balance due, court costs and accrued interest.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

X_____ Date _____