**PATIENT INFORMATION**

**BURTON DENTAL CENTER,P.C.**
**P.O. BOX 90459**
**BURTON MI 48509 (810) 744-0433**

**PATIENT NAME:**________________________________

Preferred name:________________________________ Phone #________________________________

Address________________________________________________________________

D.O.B. ____________ S / M / D / W SS#:________________ Name of spouse Or parent________________

Employed by:____________________________ Address________________________________

May we contact you at work? Yes:______ No:______ Work Phone #________________________

Person to contact in case of emergency (Outside the home)________________________ Phone________________

Address________________________________________ Relationship________________________

Whom may we thank for referring you to our office:________________________________________

| PRIMARY INSURANCE | | |
|---|---|---|
| **SUBSCRIBER:** | | **D.O.B.:** |
| **INSURANCE COMPANY:** | **SS#** | **H / S** |
| **EMPLOYER NAME:** | **GROUP #:** | |
| **BENEFIT REP AT EMPLOYER:** | **PHONE #:** | |

| SECONDARY INSURANCE | | |
|---|---|---|
| **SUBSCRIBER:** | | **D.O.B.:** |
| **INSURANCE COMPANY:** | **SS#** | **H / S** |
| **EMPLOYER NAME:** | **GROUP #:** | |
| **BENEFIT REP AT EMPLOYER:** | **PHONE #:** | |

I hereby authorize payment to go directly to BURTON DENTAL CENTER,P.C. from my insurance company for services rendered. I understand that I am responsible for all costs of treatment, whether my insurance company pays or not. I am responsible for knowing what benefits my insurance company covers and will settle any dispute with them myself. **All payments are due at time of service.**

I understand that if I need to cancel an appointment I must call the office **by 12 noon** the previous business day to avoid a **$55.00** cancellation charge.

I understand that if a check is returned for nonsufficient funds that I will be charged a fee of **$35.00**, and all future payments must be made either with cash or a money order.

I authorize the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

**I understand that an adult must accompany any minor child to all appointments. I also understand that in a divorce situatuation the adult accompanying the minor is responsible for payment at time of service.**

The information I have given on this form is correct to the best of my knowledge.

SIGNATURE:________________________________ DATE:________________________________
**(Signature of parent if child)**

**I/We authorize BURTON DENTAL CENTER.,P.C. to obtain credit history information through Flint Credit Bureau.**

**Signature:**________________________________ **Date:**______ **Witness:**____________________