

**PATIENT INFORMATION**

PATIENT'S NAME: \_\_\_\_\_ PATIENT'S SOCIAL SECURITY #: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_  
HOME ADDRESS: \_\_\_\_\_ SPOUSE'S DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_ SPOUSE'S SOCIAL SECURITY #: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_ SPOUSE'S EMPLOYER: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ SPOUSE'S WORK NUMBER: \_\_\_\_\_  
WORK PHONE NUMBER: \_\_\_\_\_ EXT: \_\_\_\_\_ CELL PHONE NUMBER: \_\_\_\_\_  
REFERRED BY: \_\_\_\_\_ ORTHODONTIST: \_\_\_\_\_  
EMERGENCY CONTACT: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
NEAREST RELATIVE NOT LIVING WITH YOU: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_  
PHYSICIAN: \_\_\_\_\_ DENTIST: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

NAME OF RESP. PARTY: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**INSURANCE INFORMATION**

<b>DENTAL</b>	<b>MEDICAL</b>
PRIMARY INS. CO: _____	PRIMARY INS. CO: _____
INSURANCE ID #: _____	INSURANCE ID #: _____
GROUP #: _____	GROUP #: _____
POLICY HOLDER: _____	POLICY HOLDER: _____
SOCIAL SECURITY: _____	SOCIAL SECURITY: _____
DATE OF BIRTH: ____ / ____ / ____	DATE OF BIRTH: ____ / ____ / ____
EMPLOYER: _____	EMPLOYER: _____

**CONTRACT TO PAY FOR MEDICAL SERVICES:**

In consideration of professional services provided to the above patient, I/we agree to pay your customary charge for these services in full, at the time of service, regardless of my insurance status unless other arrangements are made with Eric W. Nelson, M.D., D.D.S., P.A. I/we authorize Dr. Nelson to receive assignment of insurance payments. If the customary charges are more than the benefits allowed under the responsible party's insurance plan, I/we agree to pay the difference. I understand that a finance charge of 1.75% monthly (21% APR) will be added to my outstanding balance after 60 days.

**AUTHORIZATION TO RELEASE INFORMATION:**

Eric W. Nelson, M.D., D.D.S., P.A., is hereby authorized to release any medical or incidental information that may be necessary for either medical care or in processing requests for financial benefit.

**LEGAL RESPONSIBLE PARTY:**

If the patient is a minor or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient and assume financial responsibility for services given.

I certify this information is true and correct to the best of my knowledge and will notify the office of any changes to my personal information.

\_\_\_\_\_  
PATIENT OR GAURDIAN SIGNATURE

\_\_\_\_\_  
DATE