Welcome

Dr. J.T. Wilson
Dr. Gregg A. Wilson
General and Cosmetic Dentistry
10497 Garverdale Ct., Suite 107
208-375-5720

To help us meet all your dental health-care needs, please fill out this form completely in ink.

PERSONAL INFORMATION

Name _____ Date _____

Prefers to be called _____ Please circle: Male Female

Please circle: Minor Single Married Divorced Widowed Separated

Birth date _____ Social Security# _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Employer _____ Work Phone _____ Ext. _____

Do you have dental insurance? _____ Referred by: _____

In the event of an emergency, whom should we contact?

Name _____

Relationship _____ Work _____ Home _____

RESPONSIBLE PARTY

Complete if different than above

Name _____ Please circle: Mr. Mrs. Miss Ms.

Relationship to Patient _____

Birth date _____ Social Security # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Employer _____ Work Phone _____ Ext. _____

Over

DENTAL INSURANCE INFORMATION

Primary Insurance	Additional Insurance
Name of Insured _____	Name of Insured _____
Relationship to Patient _____	Relationship to Patient _____
Insured's Birth date _____	Insured's Birth date _____
Social Security # _____	Social Security # _____
Employer _____	Employer _____
Employer Phone # _____	Employer Phone # _____
Occupation _____	Occupation _____
Insurance Company _____	Insurance Company _____
Address _____	Address _____
Group # _____	Group # _____
Ins. Co. Phone # _____	Ins. Co. Phone # _____
Deductible _____	Deductible _____
Max. Annual Benefit _____	Max. Annual Benefit _____

FINANCIAL ARRANGEMENTS AND AUTHORIZATION

I authorize Dr. Wilson to release any information or records concerning dental examination, diagnosis, or treatment for myself or my children, during the period of such dental care, to any third party payers and/or health practitioners;

I further authorize and request my insurance to pay the benefits, otherwise payable to me, directly to Dr. Wilson.

I understand that my insurance carrier may pay less than the full amount due for the services rendered. I agree to be responsible for payment for any or all services rendered on my behalf or that of my dependents.

Full payment is expected at the time services are provided, unless prior financial arrangements have been made. For your convenience, we offer the following methods of payment. Please check the option you prefer:

Cash____ Personal Check____ Credit Card:____
I wish to make alternate payment arrangements. _____

Finance Charges

If I do not pay the entire new balance within 90 days of the treatment date, a finance charge of 1.5% per month (18% APR)will be assessed on the unpaid balance. I agree to pay such finance charges.

I realize that failure to keep this account current will result in treatment being rendered on a cash basis only.

I certify that the above information is true and correct, and consent to a credit check based on this information.

_____

Signature of patient (or parent if patient is minor) Date