S. RANGRASS D.D.S., PC

1719 East G Ave. / Kalamazoo, MI 49004 / (269)382-5327

PATIENT INFORMATION

☐ ***Check this box if this is a new address***

DATE_____

PATIENT NAME _____ BIRTHDATE _____AGE_____ SEX: M F
(FIRST) (M) (LAST)

HOME ADDRESS_____CITY_____ZIP_____

EMAIL ADDRESS_____HOME PHONE_____

CELL PHONE_____ EMERGENCY CONTACT NAME & NUMBER_____

SOCIAL SECURITY NUMBER_____

EMPLOYER_____ EMPLOYER'S ADDRESS_____

OCCUPATION_____ WORK PHONE_____

NAME OF SPOUSE_____ SPOUSE'S EMPLOYER_____ WORK PHONE_____

PERSON RESPONSIBLE FOR ACCOUNT_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

DENTAL INSURANCE INFORMATION

☐ ***Check this box if this is new insurance***

PRIMARY DENTAL INSURANCE CARRIER

POLICY HOLDER'S NAME_____

POLICY HOLDER'S BIRTHDATE _____

POLICY HOLDER'S SOC. SEC. #_____

OR ID#_____

POLICY HOLDER'S EMPLOYER_____

INSURANCE CO._____

GROUP #_____

SECONDARY DENTAL INSURANCE CARRIER

POLICY HOLDER'S NAME_____

POLICY HOLDER'S BIRTHDATE_____

POLICY HOLDER'S SOC. SEC.#_____

OR ID#_____

POLICY HOLDER'S EMPLOYER_____

INSURANCE CO._____

GROUP #_____

IF YOU ARE NOT COVERED BY DENTAL INSURANCE, WHAT FORM OF PAYMENT WILL YOU BE USING TODAY?

☐ CASH ☐ CHECK ☐ CREDIT CARD

CONSENT AND ASSIGNMENT

The undersigned hereby authorizes Dr. Rangrass to take X-Rays, study models, photographs or other diagnostic aids deemed appropriate by Dr. Rangrass to make a thorough diagnosis of the patient's dental needs. I also authorize the release of any of this information necessary to process insurance claims.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1½% late charge (18% APR) may be added to my account. In addition, I authorize payment of insurance benefits directly to Dr. Rangrass.

If an outside collection agency is used, I will be responsible to pay additional collection costs of up to 50% of the principal balance at the time of placement.

PATIENT SIGNATURE _____ DATE_____