Welcome to Hopewell Dental, P.C.

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help!

Patient Information (CONFIDENTIAL)

NAME _____ Date of Birth_____ Home Phone _____

Address _____ City _____ State/Zip _____

Cell Phone _____ Soc. Sec. _____

Whom May We Thank for Referring You? _____

Responsible Party

Name of Person Responsible for this Account_____

Relationship to Patient_____ Home Phone_____

Address _____ City _____ State/Zip _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate_____ SSN_____ Date Employed_____

Name of Employer_____ Union or Local #_____Work Phone_____

Address of Employer_____ City_____ State/Zip_____

Insurance Company_____ Group #_____ Policy ID #_____

Insurance Co. Address_____ City_____ State/Zip_____

IF YOU HAVE ADDITIONAL INSURANCE PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate_____ SSN_____ Date Employed_____

Name of Employer_____ Union or Local #_____Work Phone_____

Address of Employer_____ City_____ State/Zip_____

Insurance Company_____ Group #_____ Policy ID #_____

Insurance Co. Address_____ City_____ State/Zip_____

Payment Policy: We cannot guarantee any estimated coverage when billing insurance. You are ultimately responsible for any remaining amount unpaid by insurance. There will be a $20 service fee on any returned checks. All unpaid balances are subject to a 10% processing fee and will incur a 1.5% monthly finance charge. All delinquent balances must be paid prior to incurring any new charges.

Patient's Signature _____ **Date** _____