Pulos Family Dentistry, LLC 1002 N Mitthoeffer Suite B Indianapolis, IN 46229 317-898-6666

ADULT PATIENT INFORMATION RECORD (please print) Today's Date:_____

First Name:_____ M.I.:_____ Last Name:_____

Nickname:_____ Email Address(es):_____

Address:_____ City:_____ State: _____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____(ext)_____

Social Security #:_____ Driver's License #:_____expiration_____

Age: _____ Date of Birth:_____ Sex (pick one): *Male* ☐ *Female* ☐ Marital Status(pick one): *Married* ☐ *Single* ☐

Height: _____ Weight:_____ Referred by:_____

Employer:_____ Phone:_____

Employer Address:_____ City:_____ State: _____ Zip:_____

Spouse Name:_____ Date of Birth:_____

Spouse Social Security #:_____ Spouse Employer:_____

Address:_____ City:_____ State: _____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____(ext)_____

Financial Information Who is responsible for your account? (pick one): *Self* *Spouse* *Other*
(If you are responsible for your own account you may skip this section.)

Responsible Party First Name:_____ M.I.:_____ Last:_____

Address:_____ City:_____ State: _____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____(ext)_____

Social Security #:_____ Driver's License #:_____expiration_____

Age: _____ Date of Birth:_____ Sex (pick one): *Male* ☐ *Female* ☐ Marital Status(pick one): *Married* ☐ *Single* ☐

Employer:_____ Phone:_____

Employer Address:_____ City:_____ State: _____ Zip:_____

Insurance Information

Policy Holder First Name:_____ M.I.:_____ Last:_____

Relationship to Patient(pick one): *Self* ☐ *Spouse* ☐ *Parent* ☐ *Other* ☐ Social Security #:_____ Date of Birth:_____

Carrier ID#:_____ Employer:_____ Group #:_____

Dental Insurance Company:_____ Effective Date:_____Used this calendar year (pick one): *YES* ☐ *NO* ☐

Financial Arrangements and Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we will assist you in filing your claims. However, you must realize your insurance is a contract between you, your employer and your insurance company. Pulos Family Dentistry, LLC is not a party in that contract. If your insurance does not pay within 90 days, we will require you to pay the account balance in full and wait for reimbursement from your insurance. I understand and agree that regardless of my insurance status, I am responsible for the balance of my account. In the event my account goes unpaid, I understand that a finance charge of 1.5% will be added to the balance of my account. I understand that I will be held responsible for the cost of collecting my unpaid account, including but not limited to: court fees, attorney fees and collection fees. There will be a $25.00 service fee for all returned checks. _____Initial

I authorize the release of all medical information necessary to process my claims. I authorize the release of this same information, when necessary to other providers rendering medical/dental care. I assign all dental benefits and payments to Pulos Family Dentistry, LLC. A photocopy of this assignment is to be considered as valid as the original. _____Initial

ALL ESTIMATED COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.
We accept Master Card / VISA / Discover / Debit Cards / CASH / CHECK / Care Credit

Care Credit Account #:_____ Available Credit:$_____

PATIENT SIGNATURE:_____ DATE:_____

---------- Office Use Only ---------- *CASH / INSURANCE / CARE CREDIT*

WITNESS SIGNATURE:_____ DATE:_____