JOHN P. BELBAS, D.D.S.
FAMILY DENTISTRY

3513 Thomas Dr. • Suite 8 • Lakeville, New York 14480 • (585) 346-5220

PATIENT INFORMATION **DATE** ______________

NAME: ______________________________ ❒ MARRIED ❒ SINGLE ❒ MINOR ❒ MALE ❒ FEMALE
LAST FIRST M

ADDRESS: ______________________________
STREET APT.# CITY STATE ZIP

BIRTHDATE: ______________ TELEPHONE: ❒ ______________ ❒ ______________
MO DAY YR HOME OFFICE

PLACE OF EMPLOYMENT (OR SCHOOL):______________ GRADE:______ S.S.# ______________

Has any member of your family ever been treated in our office? ❒ YES ❒ NO

Whom may we thank for referring you to our office?/ How did you hear about our office?: ______________

DENTAL INSURANCE INFORMATION

	PRIMARY	SECONDARY
Subscriber:	LAST FIRST M	LAST FIRST M
Address:	STREET CITY STATE ZIP	STREET CITY STATE ZIP
Telephone #:	HOME # WORK #	HOME # WORK #
Birthdate/SS#:	MO DAY YR SS#	MO DAY YR SS#
Employer:	EMPLOYER	EMPLOYER
Dental Insurance Co.: Group#:	DENTAL INSURANCE GROUP #	DENTAL INSURANCE GROUP #

PERSON RESPONSIBLE FOR ACCOUNT CHECK ONE:

❒ Patient ❒ Father (or Husband) ❒ Mother (or Wife) ❒ Guardian

Does Responsible Party currently have an account with this office? ❒ Yes ❒ No

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

NAME ______________________________
LAST FIRST M

ADDRESS ______________________________
STREET CITY STATE ZIP

PHONE # ______________________________

FINANCE CHARGE

If I do not pay the entire New Balance within 25 days of the monthly billing date a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $134.00) which is an ANNUAL PERCENTAGE RATE OF 18% applied to the last month's balance. In the case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

X ______________________________ **DATE** ______________

❒ Patient ❒ Father (or Husband) ❒ Mother (or Wife) ❒ Guardian