NORTHERN DENTAL GROUP

William R. Gillette, D.D.S. • Eric J. Hayhurst, D.D.S.
421 Stimpson (U.S. 31) • P.O. Box 275 • Pellston, MI 49769 • (231) 539-8467 • FAX (231) 539-8466

Patient Information

Patient Name: _____ Date: _____
Last First MI
☐ Male ☐ Female ☐ _____ ☐ Married ☐ Single ☐ Child ☐ Other _____
Social Security #: _____ Birth Date: _____
Phone Home#: _____ Cell#: _____
Address: _____
Street City State Zip Code
Email Address: _____
Employer Name: _____ Employer Phone #: _____

Dental Insurance Information

Primary Insurance
Name of Subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI
Subscribers Birth Date: _____ ID #: _____ Group #: _____
Subscribers Employer Name: _____
Name of Insurance Company: _____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance
Name of Subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI
Subscribers Birth Date: _____ ID #: _____ Group #: _____
Subscribers Employer Name: _____
Name of Insurance Company: _____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Responsible Party Information
If signing for a minor please fill out the below.

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____
Social Security #: _____ Birth Date: _____
Phone Home #: _____ Cell #: _____ Work #: _____ Best time to call: _____
Street Address: _____ City, State, Zip: _____
_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Cost of treatment not covered by insurance must be paid at the time of service.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.
This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, if the amount we anticipate from the insurance company is not paid in full it is the patient's responsibility to pay the difference.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered.
I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Whom may we thank for referring you to our office? _____