WELCOME

We would like to take this opportunity to welcome and thank you for joining our dental practice. We appreciate your confidence in us and we will do everything possible to provide you with the finest dental care. Please take a few minutes to answer the following questions so we can assist you with your dental needs. The better we communicate, the better we can care for you.

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL.

ABOUT YOU

Today's date ______________________________
Month Day Year

Social Security # ______________________________

Name: ______________________________
Last First Middle Initial

I like to be called: ______________________________

Home Address: ______________________________

____
Apt/Condo # City State Zip Code

Email

____

Home Phone:

____

Work Phone: ______________________________Ext.#

____

Beeper/Cell Phone: ______________________________

Mailing Address, If Different:

Address:

____

____
Apt./Condo # City State Zip Code

Your Employer:

____

Occupation: ______________________How long held: _______

Birthday: ______________________ ❑ Male ❑ Female
Month Day Year

❑ Single ❑ Married ❑ Divorced ❑ Widowed

Spouse's Name:

____

Referred by:

____

In the event of an emergency, is there someone who lives near you that we could contact?

INSURANCE BENEFITS

Primary Insurance Coverage

❑ Medical ❑ Dental

Policy Holder: ______________________________

SSN # ______________________ Birth-

dates:_______________

Insurance Company: ______________________________

Carrier Address: ______________________________
City State Zip Code

Group #: ______________________________

Employer's Name: ____________________ Phone: _________

Employer's Address: ______________________________

Do you have any other Insurance Coverage?

❑ Yes ❑ No

This coverage is through ❑ Spouse ❑ Parent

Policy holder: ______________________________

SSN # ____________________Birthdates:

____

Insurance Company: ______________________________

Carrier Address:______________________________
City State Zip Code

Group# ______________________________

RELEASE OF INFORMATION

I authorize the release of any information necessary to process my claims.

Signature: ______________________________

ASSIGNMENT OF BENEFITS

To avoid misunderstanding regarding insurance, we wish our patients to know that ALL PROFESSONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare necessary forms or reports to help you to obtain your benefits from insurance companies. We do not render our services or the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient. There will be an additional fee for letter or reports.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be payable directly to the undersigned dentist and I am financially responsible for non-covered services. I also authorize the doctor to release any information requested.

I authorize treatment of the above named person and agree to pay all fees charged for such treatment. I agree to pay all charge for members of my family and myself, shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing.

SIGNED: ______________________________DATE: ___________
(Responsible Party) ____________________