Today's Date_____

Wauwatosa Dental Group

2600 North Mayfair Road ▪ Wauwatosa, WI 53226 ▪ 414 / 257-3366

PATIENT INFORMATION & INSURANCE DATA

Name_____ D.O.B.____/____/____
First *Middle* *Last* *Mo/Day/Year*

Check One ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated S.S. #____/____/____

Residence Address:_____
Street or P.O. Box # City State Zip

Residence Phone:_____ Cell Phone:_____ Business Phone:_____

May we contact you at work? ☐ Yes ☐ No

Address where statement should be sent if different than above:

_____
Name Address

Whom may we thank you for referring you to us?

Name_____

Address_____

City, State, Zip_____

If you have dental insurance which may assist you with a portion of your account, please complete the following:

Employee_____ D.O.B.____/____/____ S.S.#____/____/____

Employer_____ Insurance Co._____

Position_____

Effective Date_____ Insurance Co. Address_____

Is this an HMO? ☐ Yes ☐ No

_____

_____

Subscriber or Policy #:_____ Group or File #_____

Relationship of Patient to Employee: *Check One:* ☐ Self ☐ Child ☐ Spouse ☐ Other

Additional Coverage? ☐ Yes ☐ No *If yes, please compete this section also.*

_____

Employee_____ D.O.B.____/____ S.S.#____/____/____

Employer_____ Insurance Co._____

Position_____

Effective Date_____ Insurance Co. Address_____

Is this an HMO? ☐ Yes ☐ No

_____

_____

Subscriber or Policy #:_____ Group or File #_____

Relationship of Patient to Employee: *Check One:* ☐ Self ☐ Child ☐ Spouse ☐ Other

(please complete both sides)

MEDICAL COVERAGE:

Employee_____ D.O.B.____/____/____ S.S.#____/____/____

Employer_____ Insurance Co._____

Effective Date_____

Is this an HMO? ☐ Yes ☐ No

If this is an HMO, which facility are you registered with_____

_____

Subscriber or Policy #:_____ Group or File #_____

Relationship of Patient to Employee: *Check One:* ☐ Self ☐ Child ☐ Spouse ☐ Other

Additional Medical Coverage? ☐ Yes ☐ No *If yes, please compete this section also.*

Employee_____ D.O.B.____/____/____ S.S.#____/____/____

Employer_____ Insurance Co._____

Effective Date_____

Is this an HMO? ☐ Yes ☐ No

If this is an HMO, which facility are you registered with_____

_____

Subscriber or Policy #:_____ Group or File #_____

Relationship of Patient to Employee: *Check One:* ☐ Self ☐ Child ☐ Spouse ☐ Other

MINOR CHILD RELEASE

I give my permission to Dr. _____and/or his designated assistant to perform any and all dental techniques and procedures, including but not limited to the administration of nitrous oxide sedation and anesthetics, on my minor child(ren),_____, whether or not I am present at the actual appointment when the treatment is rendered. I further expressly agree to be financially responsible for all treatment rendered to the above named child(ren).

Signed_____ Date_____

SIGNATURE ON FILE

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____HEREBY AUTHORIZE _____TO PAY
(Name of Insured) (Name of Company)

and hereby assign directly to Wauwatosa Dental Group, all dental benefits, if any, otherwise payable to me for services as described on the attached forms. I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to Wauwatosa Dental Group. Authorization is hereby given to release all information necessary to the payment of said benefits.

_____
(AUTHORIZED SIGNATURE OF COVERED PERSON/EMPLOYEE)

_____
(DATE)