
PATIENT'S NUMBER

Patient's Name _____

Last First Initial

If Child Parent's Name

_____

Last First Initial

Address

_____

City _____

State _____ Zip Code _____

Phone _____ Cell _____

E-Mail _____

Dental Insurance _____

Method of Payment:

❑ Insurance ❑ Credit Card ❑ Cash

Purpose of Call _____

Other Family Members in This Practice

_____

_____

Whom May We Thank For This Referral

_____

Personal

Hobbies/Interests _____

_____

Date _____ Date of Birth _____ ❑ Male ❑ Female

DENTAL INSURANCE 1ST COVERAGE

Responsible Party _____

Employee Date of Birth _____

Employer _____

Name of Insurance _____

Address _____

Phone _____

DENTAL INSURANCE 2ND COVERAGE

Responsible Party _____

Employee Date of Birth _____

Employer _____

Name of Insurance _____

Address _____

Phone _____

RELEASE:

I authorize the dentist to perform procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less then the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments not paid, in whole or in part by my dental care payor.

I attest to accuracy of the information on this page.

In the event my account is referred to an attorney or collection agency for collection I agree to pay for processing or convenience fees if required as a cost of collection of my account. I understand that such fees would only be incurred if I optionally choose to pay the account by credit card or check by phone to the attorney or agency.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____