PATIENT INFORMATION

Welcome to our office. Payment is expected in full at the time of service. We accept most major credit cards, cash, or a personal check.

Patient's Name:______________________________ Today's Date______________

Sex:_____ Age:_____ Birth Date: ____________ Soc. Sec. #__________________

Address:____

City:__________________________ State:_______________ Zip:______________

Phone:_____________________E-Mail:__________________________________

Spouse's Name (if child, Parent's Name):______________________________
Referring Dentist:____
Reason for Visit:____
Name, Phone Number & Location of Pharmacy: ___________________________

INSURANCE CLAIM FILING & FINANCIAL REQUIREMENTS

As a courtesy, we will file your insurance claim for you. However, the ultimate responsibility for the balance on your account is yours. The deductible and/or any estimated co-pay portion not covered by your insurance is due on the date of service. If secondary insurance is carried, we will file the secondary claim once payment is received from the primary insurance.

Name of Primary Dental Insurance:______________________________________

Group #:____________________________ Member ID #:______________________

Insurance Holder's Name:______________________________Date of Birth:____________

Soc. Sec. #__________________________ Relationship to Insured:________________

Address if different from above:____

City:__________________________ State:_______________ Zip:______________

Employer:____

I have read and understand the above information and certify that I am the patient or duly authorized representative of the patient, authorized to furnish the information requested. I understand that even if I have dental insurance coverage, I am responsible for payment of the treatment provided. I also authorize the release of any dental information necessary to process the insurance claim.
Signature:____ Date:________________