

Documents

PATIENT INFORMATION SHEET

ACCOUNT INFORMATION

Patient Name: _____
Sex: _____
Address: _____
City: _____, State: _____
Zip: _____
Telephone (Home): _____
Telephone (Work): _____
Telephone (Cell): _____
Occupation: _____ Employer: _____
Email (One per family): _____
If under 18 years of age,
Mothers Name: _____ Fathers Name: _____
If full-time student (over 18),
School or University: _____

EMERGENCY CONTACT

Name: _____ Relation: _____
Telephone (Home): _____
Telephone (Work): _____
Telephone (Cell): _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Phone: _____
Address: _____
City: _____, State: _____
Zip: _____
ID#: _____ Group#: _____

POLICY HOLDER INFORMATION

Name: _____ Date of birth: _____
Relationship: _____
Social Security #: _____ Employer: _____
Secondary insurance information will only be needed if it is a Delta Dental Plan.

FEES/PAYMENTS/CONSENT

We make every effort to keep down the cost of dental care. You can help by paying upon completion of each visit. An estimate of the charges for any procedure will be given to you upon request. As a courtesy to our patients, we will be glad to electronically file your dental insurance for you.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible and/or co-insurance amounts or any other balance not paid by your insurance company.

The undersigned hereby authorize Doctor or associates to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk.

This signature on file is my authorization for the release of information necessary to process my claim and assignment of my insurance benefits.

Signature: _____ Date: 01/23/07