PATIENT INFORMATION (CONFIDENTIAL)

NAME ______________________________ DATE ____________

ADDRESS______________________ CITY______________ STATE______ ZIP______

E-MAIL ________________ CELL PHONE______________ HOME PHONE____________

SS#________________ BIRTHDATE ____________ ☐MALE ☐FEMALE

DRIVERS LICENSE #:______________ STATE ISSUED: ________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

INSURANCE INFORMATION

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SS#/ID # ________________

NAME OF EMPLOYER________________ INSURANCE CO________________

GROUP # ________________ TELEPHONE #:________________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐YES ☐NO *IF YES, COMPLETE THE FOLLOWING:*

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SS#/ID # ________________

NAME OF EMPLOYER________________ INSURANCE CO________________

GROUP # ________________ TELEPHONE #:________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT________________ RELATIONSHIP TO PATIENT________

BIRTHDATE________ DRIVERS LICENSE #________________ SS#____________

ADDRESS ______________________________ HOME/CELL #: ____________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES ☐ NO ☐

☐ It is important to understand that your dental insurance benefits are between ***YOU***, your ***employer*** and the ***insurance company***. As a courtesy, we call your insurance company and strive to get you the best coverage possible for every service. You are responsible for any remaining balances after your insurance pays, even if your insurance does not pay what they told us they would pay. It is ***YOUR*** responsibility to pay for any services received at Delavan Family Dentistry, regardless of the amount that your insurance company pays or estimates they will pay.

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Delavan Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

X______________________________ ____________________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN, IF MINOR **DATE**