Patient Information Sheet

Patient Name: _____ (preferred)_____
Social Security Number: _____ Date of Birth: ____/_____/_____
Address: _____
City: _____ ZIP _____
Home Phone #:_____ Work Phone #:_____
Cellular Phone#_____ Preferred # (circle) Home Work Cell
If minor, parent or guardian name: _____

Our office acquires new patients exclusively through referrals, who may we thank for referring you to our office? _____

Emergency contact name: _____ Phone #: _____
Address: _____
_____

Insurance Information:

Name of insured: _____
SS# of Insured: _____ DOB of insured: _____
Insured's employer: _____
Insurance company name: _____
Insurance company address: _____
Insurance company customer service #: _____
Group#: _____ ID#: _____
Do you carry dual insurance benefit coverage? _____

Financial Acknowledgement:

1. If you will be using dental insurance to assist with reimbursement for the services provided to you through this office, we will make every effort to maximize your benefits and assist you with the processing of your dental insurance claims.
2. Your "out of pocket" costs will be estimated based on information we receive from your insurance company. For patients with insurance and those without, **your estimated costs will be collected on the day your services are received**. Ultimately, you are responsible for the fees incurred from services rendered through this office.
3. Your insurance company has a 30-day time frame to provide reimbursement to your dental care provider. Additional lengths of time may require communication with your insurance company. Both you, and your dental care provider have the ability to review unpaid benefits with your insurance carrier.
4. If an additional insurance plan is being used, all claims will be sent to your secondary insurance as a *courtesy* to you.

Patient signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____