THE DENTAL
ANESTHESIA CENTER

Welcome to Our Practice!

Whom may we thank for referring you? _____

CHILD/DEPENDENT PATIENT INFO

Date _____

Last Name _____ First _____ MI _____

Patient Address _____ City _____ ST _____ Zip _____

Sex ☐ M ☐ F ☐ Child 18↓ ☐ Dependent 19↑ ☐ at home ☐ college

Birthdate _____ E-mail _____

We realize many families are in a state of change. Divorced, Separated, and blended families are common. The policy in our office states, **"It is the responsibility of the Parent or Guardian, requesting care to assure this office of complete and prompt payment."**

Who is accompanying Child/Dependent today? ☐ Parent ☐ Grandparent ☐ Other

Parents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If Divorced, who has custody concerning health/dental decisions? _____

Birth Mother Name _____ Birthdate _____

Address _____ City _____ ST _____ Zip _____

Home Ph _____ Cell _____ Work _____

Employer _____ SS# _____

Birth Father Name _____ Birthdate _____

Address _____ City _____ ST _____ Zip _____

Home Ph _____ Cell _____ Work _____

Employer _____ SS# _____

BILLING INFO

Payment is due at the time of service. We accept CASH, CHECK, MC, VISA, DISCOVER and CARECREDIT. As a courtesy to our Patients, we will submit dental insurance. Co-payment is estimated and due at the time of service. You are financially responsible for your account balance, including any portion your Insurance does not pay.

INSURANCE INFO

Primary Policy Holder Name _____ Birthdate _____

SS# _____ ID# _____ Group# _____

Employer _____

Primary Insurance Company _____ Ins Co Ph # _____

Secondary Policy Holder Name _____ Birthdate _____

SS# _____ ID# _____ Group# _____

Employer _____

Secondary Insurance Company _____ Ins Co Ph # _____

AUTHORIZATION AND RELEASE

I authorize the Dentist to release any information, including records of examination, diagnosis, and treatment rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or behalf of my dependents.

PATIENT AUTHORIZED INSURANCE FORM

THE FOLLOWING APPLIES TO ALL INSURANCE PLANS. IT PROVIDES THE OFFICE WITH AN ORIGINAL SIGNATURE ON FILE, SO SIGNATURE ON CLAIM AT EACH APPOINTMENT IS NOT NECESSARY.

The undersigned, hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned personally signed the particular claim.

Primary: _____ _____
Date

Secondary: _____ _____
Date

LATE CHARGES

If I do not pay the entire balance within 25 days of the monthly billing date, or upon final insurance payment, a billing late charge of $10.00 will be assessed each month. I realize that the failure to keep this account current may result in termination of additional services except for dental emergencies in which prepayment will be necessary. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on any outstanding balances.

Thank You for providing the information necessary to help us serve your dental healthcare needs effectively and efficiently. If you have any questions, please ask.

Check appropriate box: ☐ will remain here as patient ☐ returning to referring dentist

Emergency Contact _____ PH _____ Relationship _____

X _____