ALLEN AD DENTAL

Patient Information

Please fill this form out completely. Each question is important. If you have any questions please ask. Thank You!

Personal Information

Today's Date _____ Patient's Name _____

Preferred Name _____ Patient's Birthdate _____ Social Security # _____

Status: ☐Child / Adult ☐Single ☐Married ☐Divorced ☐Widowed Spouse's Name _____

E-mail (only used to confirm appointments) _____

Billing Address _____

_____

Home Phone # _____ Cell Phone # _____

Employment *(parent, if patient is a minor)*

Employer _____ Position _____

Address _____ Work phone # _____

Spouse's employer _____ Work phone # _____

School Information (College / University Only)

Student Status: Full time / Part time

School _____ Expected date of graduation _____

Whom may we thank for referring you!

Name _____ Address _____

Dental Insurance *(We'd like to photocopy any dental insurance cards you may have.)*

Employee Name _____ Birthdate _____ Soc.Sec.# _____

Relationship to employee _____ Employer _____

Insurance Company _____

Secondary Insurance - Employee Name _____ Birthdate _____

Soc.Sec.# _____ Insurance Company _____

Signature on File

The undersigned hereby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependants. I further expressly 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 dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, (name of insured) _____ hereby authorize (Insurance Company) _____ to pay and hereby assign to Allen Dental all dental benefits, if any, otherwise payable to me for their services as described on the attached forms.

I understand I am financially responsible for all charges incurred for the dental treatment provided. Accounts aged over 60 days, interest will be charged at a rate of 1.5% monthly.

Signature of Covered Person / Patient _____ Date _____

(Parent sign for child. Thank you.)