

## Patient Information *(Confidential)*

Date _____	Name _____	Birthdate _____	SS# _____	
Address _____	City _____	State _____	Zip _____	
Employer: _____	Phone numbers	Home _____	Work _____	Cell _____
Best time to Contact _____ (check appropriate box)	Home	Work	Cell	Email Address _____
Status (check appropriate box)	Single	Married	Child	Other
If college student, Name & City of College _____	Full time	Part time		

## Account Information *(if same as patient, enter Self)*

Person responsible for account _____	Relationship to Patient _____				
Address _____	City _____	State _____	Zip _____		
(if different than patient)	Birthdate _____	SS# _____	Drivers license # _____		
Phone numbers: Home _____	Work _____	Cell _____			
Employer _____	Best place to contact	Home	Work	Cell	E-mail _____

## Primary Dental Benefit Information

Insurance Company Name _____	Group # _____	Union/Local _____
Address _____	Phone Number _____	
Name of Insured _____	Relationship to Patient _____	
Employer _____	Birthdate _____	SS/ID # _____

I consent to your use and disclosure of protected health information to carry out payment activities in connection with dental claims. I understand that I am responsible for all costs of dental treatment.	I hereby authorize and direct payment to Heart of the City Dental of dental benefits otherwise payable to me.
X _____ Signed Patient/Guardian	X _____ Signed Patient/Guardian

Do you have additional dental benefits? If yes, please complete the following

## Secondary Dental Benefit Information

Insurance Company Name _____	Group # _____	Union/Local _____
Address _____	Phone Number _____	
Name of Insured _____	Relationship to Patient _____	
Employer _____	Birthdate _____	SS or ID # _____

### Payment Is Due at Time of Service

Non-Dental benefit coverage accounts – payment in full at time of service.

Dental Benefit coverage accounts – estimated patient portion at time of service.

### Dental Benefits

Dental benefit coverage information is the sole responsibility of the patient/subscriber.

Patient portions are **estimates** only based upon information received and due at time of service, any remaining balance after insurance is due upon receipt of your statement.

I have read, completed and understand the above information. I also understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered. I further understand that a finance charge will be added to any balance over 60 days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required.

**Patient/Guardian Signature** X \_\_\_\_\_ **Date:** \_\_\_\_\_