Patient Account & Insurance Information

Patient:

Name: Mr. / Mrs. / Ms. / Dr. _____ (First) ____ (M.I.) _____ (Last) Birthdate: _____ (month) _____ (day) _____ (year)

School Attending (if student):_____ City:_____ State: _____

Date of Last Dental Visit: _____ Procedures Performed this Year: _____

Spouse:

Name: Mr. / Mrs. / Ms. / Dr. _____ (First) ____ (M.I.) _____ (Last) Marital Status: Married / Separated / Partnered / Widowed / Divorced

Children:

Name(s) and Ages: _____

Emergency Contact:

Name: Mr. / Mrs. / Ms. / Dr. _____ (First) ____ (M.I.) _____ (Last) Relation to Patient: _____

Home Address: _____ (Street) _____ (Suite)

_____ (City) _____ (State) _____ (Zip Code)

Home Phone #: (_____) _____

Other Phone #: (_____) _____

Primary Insurance Carrier:

Policy Holder Name: _____ (First) _____ (Last) Birthdate: _____ (Month) _____ (Day) _____ (Year)

Social Security Number: _____ Relation to Patient: _____ Home Phone #: (_____) _____

Employer: _____ Work Phone #: (_____) _____

Work Address: _____ (Street) _____ (Suite) Occupation: _____

_____ (City) _____ (State) _____ (Zip Code) Date Policy Began: _____

Insurance Company: _____ Type (Ex. Premier): _____

Insurance Address: _____ (Street) _____ (Suite) Insurance Phone #: (_____) _____

_____ (City) _____ (State) _____ (Zip Code) Group/Policy #: _____

Secondary Insurance Carrier:

Policy Holder Name: _____ _____ Birthdate: _____ _____ _____
First Last Month Day Year

Social Security Number: _____ Relation to Patient: _____ Home Phone #: (_____) _____

Employer: _____ Work Phone #: (_____) _____

Work Address: _____ _____ Occupation: _____
Street Suite

_____ _____ _____ Date Policy Began: _____
City State Zip Code

Insurance Company: _____ Type (Ex. Premier): _____

Insurance Address: _____ _____ Insurance Phone #: (_____) _____
Street Suite

_____ _____ _____ Group/Policy #: _____
City State Zip Code

Medical Insurance Carrier:

Policy Holder Name: _____ _____ Birthdate: _____ _____ _____
First Last Month Day Year

Social Security Number: _____ Relation to Patient: _____ Home Phone #: (_____) _____

Employer: _____ Work Phone #: (_____) _____

Work Address: _____ _____ Occupation: _____
Street Suite

_____ _____ _____ Date Policy Began: _____
City State Zip Code

Insurance Company: _____ Type (Ex. Premier): _____

Insurance Address: _____ _____ Insurance Phone #: (_____) _____
Street Suite

_____ _____ _____ Group/Policy #: _____
City State Zip Code

Additional Information:

Whom may we thank for referring you to our office? Mr.
Mrs.
Ms. _____ _____ _____
Dr. First M.I. Last

Do you have any special requests? _____

Consent:

1. I authorize this office to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I have received from this office copies of the Dental Materials Fact Sheet and the Notice of Privacy Practices.
3. I authorize this office to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.
4. I permit this office to communicate with my dental insurance provider(s) in order to estimate my benefits and to submit claims on my behalf.
5. I permit this office to communicate with my medical insurance provider(s) in order to estimate my benefits and to submit claims on my behalf.
6. I authorize payment directly to Lori Ross Tijerino, DDS, Inc. of the dental benefits otherwise payable to me.
7. I understand that there is usually an annual deductible fee that I must satisfy before my insurance provider(s) will accept claims.
8. I know that insurance providers pay only a percentage of each procedure, and that there is an annual maximum that insurance pay out.
9. I accept that my insurance provider(s) may deny my claims, and that I will be responsible to pay for all services rendered in this office.
10. I agree to pay a sixty-five dollar ($65) cancelation fee for each missed appointment, when I do not provide forty-eight (48) hours notice.
11. I acknowledge that any balance over thirty (30) days will begin to accrue a finance charge of one-and-one-half percent (1 ½%) per month.

Signature of Responsible Party: _____ Date: _____ Relation to Patient: _____