Account and Patient 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 / Partnered / Separated / 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)   Home Phone #: (_____) ______________

______________________ (City) _____ (State) ________ (Zip Code)   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

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 insurance provider(s) in order to estimate my benefits and to submit claims on my behalf.
5. I authorize payment directly to Lori Ross Tijerino, DDS, Inc. of the dental benefits otherwise payable to me.
6. I understand that there is usually an annual deductible fee that I must satisfy before my insurance provider(s) will accept claims.
7. I know that insurance providers pay only a percentage of each procedure, and that there is an annual maximum that insurance pay out.
8. 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.
9. 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.
10. I acknowledge that any balance over sixty (60) 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: __________________