WELCOME

Patient Information

How is this Patient related to the Person Responsible for this account? ☐ Self ☐ Spouse ☐ Child ☐ Other (_____)

Patient Name: _____ (_____)
LAST FIRST MI PERFERRED NAME

Age: _____ Birthday: _____/_____/_____ Sex: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ D ☐ W

Social Security #: _____ Driver's License # _____ State: _____

Cell: (_____)_____ Work: (_____)_____ Home: (_____)_____

Address: _____ E-Mail: _____
STREET APARTMENT

_____
CITY STATE ZIP CODE

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Friend or Family member

☐ Our Website ☐ Online Review ☐ Mailer ☐ Yellow Pages ☐ Signage ☐ Other _____

Name of person, business or website referring you to our practice: _____

Person Responsible for this Account

The following information is for the person who will be responsible for payment of this account.

Patient Name: _____ (_____)
LAST FIRST MI PERFERRED NAME

Age: _____ Birthday: _____/_____/_____ Sex: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ D ☐ W

Social Security #: _____ Driver's License # _____ State: _____

Cell: (_____)_____ Work: (_____)_____ Home: (_____)_____

Address: _____ E-Mail: _____
STREET APARTMENT

_____
CITY STATE ZIP CODE

Employment Information

The following is for the person responsible for payment:

Employer Name: _____

Work Phone: _____

Occupation: _____

The following is for the patient:

Employer Name: _____

Work Phone: _____

Occupation: _____

Family Members

Spouse _____ DOB: _____ SSN: _____
LAST FIRST MI

Child: _____ DOB: _____ ☐ M ☐ F

Child: _____ DOB: _____ ☐ M ☐ F

Child: _____ DOB: _____ ☐ M ☐ F

Please Continue on the Back Side …

Primary Insurance Information

Name of Insured: _____ Is Insured a patient? □ Yes □ No
LAST FIRST MI

Insured's Birthday: _____/_____/_____ Insured's Social Security # _____

Insured's Address: _____
STREET CITY STATE ZIP CODE

Group Number: _____ **Employer's Name:** _____

Insurance Plan Name: _____ **Insurance Phone:** _____

Insurance Plan Address: _____

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Other Insurance Information

Name of Insured: _____ Is Insured a patient? □ Yes □ No
LAST FIRST MI

Insured's Birthday: _____/_____/_____ Insured's Social Security # _____

Insured's Address: _____
STREET CITY STATE ZIP CODE

Group Number: _____ **Employer's Name:** _____

Insurance Plan Name: _____ **Insurance Phone:** _____

Insurance Plan Address: _____

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Agreement

As a condition of your treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment in full of all dental services. This dental office does not render services on the assumption that our charges will be paid by an insurance company.

As a courtesy to our patients this office will help prepare our patients' insurance forms. In some instances we may assist in making collections from insurance companies and will credit any such collections to the patient's account. Credits shall apply to the current account balance. Refunds are issued only on current accounts with credit balances.

If you are unable to keep your appointment, please give our office 48 hours' notice. I agree that a $50.00 charge will apply to each missed appointment.

I authorize the use of my radiographs, photographs, recordings, and study models for use in case development, seminars or publications of Deborah A. Carey, DDS. I understand that fees for quoted dental care can only be extended for a period of 90 days from the date of the patient examination. I also agree to pay a $20 fee for any returned checks.

Deborah A. Carey, DDS, PC will use reasonable means to safeguard any and all confidentially protected health and/or patient information. The information you provide to us will be used by our office for the purpose of obtaining and filing insurance benefits. This includes but is not limited to your Social Security number, date of birth, diagnosis, patient history, etc.
SIGNATURE ON FILE: So you don't have to sign an insurance form at each visit, Deborah A. Carey, DDS will maintain this "signature on file" for you.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining insurance benefits payable.
AUTHORIZATION TO PAY BENEFITS TO BELOW NAMED DENTIST: I hereby authorize payment directly to Deborah A. Carey, DDS for services rendered.

I have read the above conditions of treatment and payment and agree to their content.

X_____ Date: _____
Signature of the person completing this form.

Your Relationship to the Patient: □ Self □ Person Responsible for Account □ Parent /Guardian

THANK YOU!