North End Dental Care

Patient Information Form

Date: _____

Name: _____ **Date of Birth:** _____
Address: _____ **City & State:** _____ **Zip Code:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Email: _____ **How did you hear about our office?** _____

EMERGENCY CONTACT:
Name: _____ **Phone Number:** _____
Relationship to Patient: _____

RESPONSIBLE PARTY FOR PAYMENT OF ACCOUNT:
Name: _____
Address: _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

INSURANCE INFORMATION:

PRIMARY
Name of Insured Person: _____
Relationship to Patient: _____
DOB of Insured Person: _____
SSN or Insurance ID of Insured Person: _____
Employer: _____
Union or Local Number: _____
Name of Insurance Company: _____
Insurance Company Group Number: _____
Insurance Company Phone Number: _____
Insurance Company Address: _____

SECONDARY
Name of Insured Person: _____
Relationship to Patient: _____
DOB of Insured Person: _____
SSN or Insurance ID of Insured Person: _____
Employer: _____
Union or Local Number: _____
Name of Insurance Company: _____
Insurance Company Group Number: _____
Insurance Company Phone Number: _____
Insurance Company Address: _____

INSURANCE AND PAYMENT:
Your dental insurance is a contract between you and your insurance company. We will help you obtain due benefits by preparing necessary claim forms. However, all professional services rendered are charged directly to the patient, and the patient is responsible for payment of all fees for services rendered. Initial: _____

Your co-insurance amount is due and payable at the time services are rendered. If this office is supplied with your insurance benefit information, we will make every effort to estimate your portion as accurately as possible. Any overpayment will be refunded to the appropriate party in a timely fashion. If there is still a balance due after your estimated portion and your insurance benefit is paid, then this office will bill the patient. Any remaining balance must be paid within 30 days from the date of the statement. Initial: _____

If you do not have insurance, payment in full is expected at the time services are rendered. Initial: _____

SIGNATURE ON FILE:
I authorize use of this form on all insurance submissions.
I authorize release of information to all my insurance carriers.
I understand that I am responsible for all fees for services rendered.
I authorize my insurance carrier to make payment directly to this office.

Signature of patient, parent, or guardian: _____ **Date:** _____