Patient Information

Patient Name _____ Date of Birth _____ Today's Date _____

SS # _____ Driver's License # _____ M/F ____ Marital Status _____

Address _____ City _____ State _____ Zip_____

EMAIL _____

Home # _____ Work # _____ Mobile # _____

Employer _____ Emergency Contact _____ Phone # _____

Referral Information

Name of person, office or other source referring you to our practice _____

Responsible Party

☐ **SAME AS PATIENT INFORMATION**

Name _____ M/F ____ Date of Birth _____Marital Status _____

SS # _____ Driver's License # _____

Address _____ City _____ State _____ Zip_____

Home # _____ Work # _____ Mobile # _____

Insurance Information

Insured Name _____ SS # _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name _____ Employer _____ Group # _____

Insurance Address _____

City _____ State _____ Zip _____ Phone _____

I hereby authorize any and all physicians, hospitals or medical providers to furnish *Carmel Professional Dentistry* all records, including x-rays, laboratory reports, other data or information, my medical history, diagnosis, or treatment notes, whether past, present, or future, and permit them to examine such records and hereby authorize you to permit them to make copies or furnish copies thereof. I hereby authorize the office of *Carmel Professional Dentistry* to begin and/or continue proposed treatment.

Signature _____ Date _____

Parent or Guardian if Above Patient is a Minor

Insurance: We will gladly process any standard dental claims for you. It is important to understand that any treatment rendered is done so directly for the patient, and it is the patient or guardian who is ultimately responsible for any and all fees. Payment for the treatment rendered is expected at the time of service. If you have dental insurance, as a courtesy, we will file with the primary insurance carrier only. For any insurance coverage that cannot be verified at time of treatment or for any portion that insurance does not cover, payment is expected at the visit. Account balances over 90 days will be charged interest of 1.5% per month. I hereby authorize payment directly to *Carmel Professional Dentistry* of the group insurance benefits otherwise payable to me.

Signature_____Date_____

Parent or Guardian if Above Patient is a Minor