PATIENT INFORMATION

SSN#:_____

Patient Name:_____

_____

Addrs:_____

_____

City:_____

State: _____ **Zip:**_____

Tel#:_____

Cell#:_____

Email:_____

DOB:_____ **SEX: __M __F**

Circle: Single Married Divorced

Partnered Separated Widowed

Employer: _____

Occupation: _____

Work#:_____

Who may we thank for referring you?

_____

DENTAL INSURANCE

Insurance Company:_____

Insurance Tel#:_____

Ins. Subscriber ID #:_____

Ins. Group#:_____

Who is the Subscriber on the primary insurance? :

Name:_____ _

DOB:_____

SSN#:_____

Relationship to Patient:_____

Secondary **INS Company:**_____

2nd Ins Tel#:_____

2nd Ins Subscriber ID#:_____

2nd Ins. Group#:_____

Who is the Subscriber on the 2nd Ins.? :

Name:_____

DOB:_____

SSN#:_____

Relationship to Patient:_____

IN CASE OF EMERGENCY- CONTACT INFO

Name: _____ **Tel#:**_____

Relationship: _____

ASSIGNMENT AND RELEASE

I _____certify that I, and/or my dependent(s), have Insurance coverage with _____ _____and assign directly payment to ***Acosta Cosmetic & Family Dentistry*** all insurance benefits, if any, otherwise payable to me for services rendered. The above name dental office may use my health care information and may disclose such information to the above name Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. *I understand that I am financially responsible for all charges whether or not paid by insurance*. This consent will end the day I decide to terminate my services and pay all my financial obligations to **Acosta Cosmetic & Family Dentistry**. **DATE/Sign Initials: _____**

IN CASE OF *NO INSURANCE*, I _____certify that I, and/or my dependents under my financial responsible party, am responsible for all dental service(s)/treatment(s) and/or dental products/supplies rendered at ***Acosta Cosmetic & Family Dentistry***. This consent will end the day I decide to terminate my services and pay all my financial obligations to **Acosta Cosmetic & Family Dentistry**. **DATE/Sign Initials: _____**

****I understand by signing above, that any financial obligations defaulted on my account or dependents for services rendered at Acosta Cosmetic & Family Dentistry is subject to being submitted to a collection agency. ****