Welcome

Thank you for selecting Downtowne Dental Group. We strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely. If you have any questions, please ask. We will be happy to help!

Please tell us about yourself:

Name:
_____
First Middle initial Last
Preferred name: _____
If Child, Parents Name:
_____
First MI Last
_____
First MI Last
Who is responsible for this account?
☐ Myself ☐ Other_____
Today's Date: _____
Birth date: _____
☐ Male ☐ Female
I am ☐ Single
☐ Married
☐ Other _____
Home phone number: _____
Cell phone number: _____
Home Address:
Street_____
City _____
State_____ Zip_____
Drivers license NO. _____
Person to contact in case of emergency
(Someone not living with you):
Name _____
Daytime phone number _____

Place of employment: _____
Position_____
Work phone number _____
Patient/Parent Social Security No._____
Significant other's place of employment:
_____
Significant other's current position:
_____
Other family members in this practice:
_____
How did you hear about us?
☐ Referred by patient. Name _____
☐ Phone book
☐ Web site
☐ Live in area
☐ Other _____
I prefer to be contacted at ☐ Home
☐ Work
☐ Cell phone
The best time to reach me is _____
May we communicate with you via e-mail? _____
If yes; please share your e-mail address:
_____
Method of Payment: ☐Insurance
☐Credit card
☐ Cash
Purpose of visit: _____

----------Dental Insurance Information----------

Primary Coverage

Employee Name_____
Employee Date of Birth_____
Employer_____# of years___
Name of Insurance Co._____
Address: _____
_____
Telephone_____
Program or policy # _____
Union, Local or Group _____
Social Security No._____

Secondary Coverage

Employee Name _____
Employee Date of Birth _____
Employer_____ # of year's _____
Name of Insurance Co. _____
Address: _____
_____
Telephone _____
Program or policy # _____
Union, Local or Group _____
Social Security No._____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE_____**DATE**_____