

WELCOME TO SILVERBELL DENTAL CARE

TO HELP US MEET ALL YOUR DENTAL CARE NEEDS, PLEASE TAKE A FEW MINUTES TO COMPLETE BOTH SIDES OF THIS FORM. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE ASK AND WE WILL BE HAPPY TO HELP YOU.

PATIENT INFORMATION:

NAME _____ BIRTHDATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____

IF FULL TIME STUDENT, NAME OF SCHOOL OR COLLEGE _____ CITY _____ STATE _____

PATIENT'S OR PARENT'S EMPLOYER _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

ADDRESS _____ HOME PHONE _____

INSURANCE INFORMATION:

NAME OF DENTAL INSURANCE _____ GROUP NUMBER _____

ADDRESS OF INSURANCE COMPANY _____

CITY _____ STATE _____ ZIPCODE _____ TELEPHONE NUMBER _____

NAME OF EMPLOYER _____ EMPLOYEE'S FULL NAME _____

EMPLOYEE'S BIRTHDATE _____ ID# _____

IF SECONDARY DENTAL INSURANCE IS AVAILABLE, PLEASE PROVIDE US WITH THAT INFORMATION.

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) DENTAL CARE AND TREATMENT FOR THE PURPOSE OF EVALUATING AND/OR ADMINISTERING CLAIMS FOR INSURANCE BENEFITS OR TO ANOTHER DENTIST.

I HEREBY AUTHORIZE THE ASSIGNMENT OF MY DENTAL BENEFITS TO SILVERBELL DENTAL CARE, PC. BY SIGNING MY NAME TO THIS DOCUMENT, I ALSO AGREE TO ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ANY DENTAL SERVICES PROVIDED. FULL PAYMENT FOR SERVICES, OR ESTIMATED CO-PAYMENTS, ARE DUE THE DAY OF YOUR DENTAL VISIT. YOUR PAYMENT MAY BE MADE WITH CASH, CHECK OR ACCEPTED CREDIT CARD.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/RESPONSIBLE PARTY SIGNATURE _____