WELCOME TO PARKTOWN DENTAL

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions feel free to call us.

CHART# _____

DATE _____

PATIENT INFORMATION

Name _____ Birthdate _____ SSN# _____

Home Phone# _____ Cell/Pager# _____ Email Address _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

whom May We Thank for Referring You _____

Person to Contact In Case of Emergency _____ Home Phone# _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ SSN# _____

Employer _____ Work Phone _____ Cell/Pager# _____

Method of Payment: Insurance ☐ Cash ☐ Check ☐ Credit Card ☐

Other family members in this practice _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security# _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Union/Local# _____

Address _____ City _____ State _____ Zip _____

ADDITIONAL INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security# _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Union/Local# _____

Address _____ City _____ State _____ Zip _____

AUTHORIZATION AND 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 administering claims for insurance benefits.
I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize the payment of insurance benefits directly to the dentist or dental group. Otherwise payable to me.
I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services.
I understand that 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 _____

For office Use Only: Updated by: _____ Date _____ Updated by: _____ Date _____ Updated by: _____ Date _____