WELCOME

FIRST NAME_____ MIDDLE_____LAST NAME_____

BIRTH DATE___/___/____ SEX MALE / FEMALE DRIVERS LICENSE # _____

ADDRESS_____CITY_____STATE____ ZIP_____SSN_____

PHONE: HOME_____CELL_____WORK_____ EMAIL_____

EMPLOYER_____ WHO REFERRED YOU TO OUR OFFICE?_____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

_____

PRIMARY CARD HOLDER
NAME_____
RELATIONSHIP_____
DATE OF BIRTH___/___/____
SSN_____
EMPLOYER_____
GROUP#_____

SECONDARY INSURANCE

_____

PRIMARY CARD HOLDER
NAME_____
RELATIONSHIP_____
DATE OF BIRTH___/___/____
SSN_____
EMPLOYER_____
GROUP#_____

OFFICE POLICY

OUR OFFICE WILL SUBMIT INSURANCE CLAIMS ON YOUR BEHALF. PATIENTS/GUARDIANS ARE RESPOSIBLE FOR ANY BALANCE NOT PAID BY INSURANCE.

PATIENT ESTIMATED PORTION IS DUE AT TIME OF VISIT.
PAST DUE ACCOUNTS WILL ACCRUE INTEREST, COLLECTION FEES AND ATTTORNEY FEES

THERE WILL BE A 40.00 CHARGE ON RETURNED CHECKS.

A 50.00 FEE WILL BE APPLIED TO ACCOUNTS IF WE DO NOT RECEIVE 24 HOURS NOTICE OF CANCELLATIONS.

ACKNOWLEGEMENT OF PRIVACY PRACTICES

I CERTIFY THAT I HAVE AN OPPORTUNITY TO REVIEW THIS OFFICE'S NOTICE OF PRIVACY PRACTICES AND MAY REQUEST A COPY AT ANY TIME.

INSURANCE AUTHORIZATION AND RELEASE

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO ALL DENTAL CLAIMS. I AUTHORIZE PAYMENT OF ALL INSURANCE BENEFITS BE SENT DIRECTLY TO JOHN A. WYATT D.D.S.

_____ _____

SIGNED PATIENT /PARENT DATE