Sweet TOOTH DENTISTRY

# Patient Information

Name: _____ _____ _____ _____ Male _____Female
Last First MI

Title: ___Dr. __Mr. __Mrs. __Ms. How do you wish to be addressed: _____

Address: _____
Mailing address City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Date of Birth: _____ Social Security Number: _____ Employer: _____

Who may we thank for referring you to our practice?_____

## Dental Insurance Information

Employee/Subscriber Name: _____
Last First MI

Date of Birth: _____Relation to patient: _____ Subscriber ID# _____

Group /Employee Name: _____ Group Number: _____

Insurance Company Name: _____

Claims Mailing Address: _____

Telephone Number: _____

___ I authorize release of any information concerning me/my child's health care recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.

___ I authorize payment of Insurance benefits directly to Sweet Tooth Doc, Ltd

___ I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.

___I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment.

___I agree to pay any applicable deductibles and estimated copayments on the day the dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.

___I agree to pay the total cost of the dental services rendered on the date of service if I/my child does not have dental insurance benefits.

**Patient/Guardian Signature**:_____ **Date:**_____

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