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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