HOMETOWN FAMILY
DENTISTRY

Patient Information:

Name: (First) _____ (Last) _____ (Middle Initial) ____ Preferred name: _____

Birth Date: _____ []Male []Female SSN: _____ [] married []single []divorced []widowed

Address: _____ City: _____ State: _____ ZIP: _____

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

Employer: _____

Responsible Party: [] check here if same as above

Name: _____ Birth Date: _____ SSN: _____

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

Employer: _____

Emergency Contact:

Name: _____ Phone number: _____

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

[] I authorize the release of any information concerning my/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 Hometown Family Dentistry.

[] 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 co-payments on the date 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 dental services rendered on the date of service is I/My child does not have dental insurance benefits or I if I did not provide the insurance information before appointment.

Parent/Guardian Signature: _____ Date: _____