PATIENT INFORMATION

NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

HOME PHONE: (____)_____ CELL PHONE: (____)_____ WORK PHONE: (____)_____

EMAIL:_____

PREFFERED METHOD OF CONTACT: HOME_____ CELL_____ WORK_____ EMAIL_____ TEXT_____

MALE_____ FEMALE_____ BIRTHDATE:_____ MARITAL STATUS:_____

SSN:_____ DRIVERS LICENSE/STATE ID NO:_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:_____PHONE: (____)_____

*If you are a Student please list your permanent address below:

ADDRESS:_____City:_____STATE:_____ZIPCODE:_____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF POLICY HOLDER:_____ RELATIONSHIP TO PATIENT:_____

BIRTHDATE:_____SSN:_____DL/STATE ID NO:_____

EMPLOYER:_____ EMPLOYER PHONE NUMBER: (___)_____

ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

INSURANCE COMPANY:_____PHONE NUMBER: (___)_____

ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

GROUP NUMBER:_____ POLICY HOLDER ID NO:_____

SECONDARY INSURANCE

NAME OF POLICY HOLDER:_____ RELATIONSHIP TO PATIENT:_____

BIRTHDATE:_____SSN:_____DL/STATE ID NO:_____

EMPLOYER:_____ EMPLOYER PHONE NUMBER: (___)_____

ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

INSURANCE COMPANY:_____PHONE NUMBER: (___)_____

ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

GROUP NUMBER:_____ POLICY HOLDER ID NO:_____

(OVER PLEASE)

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:_____

RELATIONSHIP TO PATIENT:_____ PHONE NUMBER: (___)_____

ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

RENT OR OWN:_____HOW LONG AT ADDRESS:_____:

EMPLOYER:_____ PHONE NUMBER: (____)_____

OCCUPATION:_____NUMBER OF YEARS EMPLOYED:_____:

*If this account is for a minor and needs to be sent to more than one party please advise our office staff.

CERTIFICATION AND RELEASE:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR IF I OR MY MINOR CHILD HAS HAD A CHANGE IN DENTAL INSURANCE. I AUTHORIZE DR. MARGARET S. GINGRICH DDS THE USE OF MY INFORMATION FOR ALL INSURANCE SUBMISSIONS AND REFERRING DOCTOR OFFICES.

ALL DISCREPANCIES IN BILLING MUST BE SETTLED WITHIN 30 DAYS OF THE FIRST BILLING DATE. ANY PERSON REQUESTING TREATMENT FOR A MINOR IS RESPONSIBLE FOR PAYMENT UNLESS OTHERWISE NOTED AND SIGNED BY RESPONSIBLE PARTY. **A RE-BILL FEE OR FINACE CHARGE IS ADDED TO EACH STATEMENT 60 DAYS OVERDUE.**

YOU MAY REQUEST A PREDETERMINATION FROM YOUR INSURANCE COMPANY PRIOR TO TREATMENT. INSURANCE QUOTES FOR SERVICES RENDERED ARE ONLY ESTIMATES. YOU ARE RESPONSIBLE FOR ANY PORTION OF THE BILL UNPAID BY THE INSURANCE COMPANY.

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED

DATE:_____ NAME (PRINT):_____

SIGNATURE:_____