WELCOME

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please don't hesitate to ask.

PATIENT INFORMATION

Date_____

Patient_____ SS#_____

Address_____ Sex: __M__F Age____ Birth date_____

_____

City state zip Marital status_____

Occupation_____ Employer_____

Employer address_____ E-mail address_____

SPOUSE INFORMATION

Spouse's Name_____ Birth date_____ SS# _____

Occupation_____ Employer_____

Whom may we thank for referring you? _____

DENTAL INSURANCE and/or ACCOUNT RESPONSIBILITY

Who is responsible for this account? _____

Relationship to patient _____ Ins. Co. _____ Group # _____

Ins. Co. address _____

Is patient covered by additional insurance? Y/N

Subscriber's Name_____ Birth date_____ SS# _____

Relationship to Patient_____ Ins. Co._____ Group # _____

Ins. Co. address _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Herremans all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

PHONE NUMBERS

Home_____ Work_____ Ext _____ Spouse's work_____

Best time and place to reach you _____

EMERGENCY CONTACT: Name_____ Relationship_____

Home Phone #_____ Work Phone_____