

PATIENT INFORMATION Please read thoroughly and make necessary corrections

Full Name: _____ Preferred Name: _____

Sex (circle): M / F DOB: / / SS#: - - Marital Status (circle): Single / Married / Divorced / Widowed

Home Address: _____ City: _____ State: _____ Zip Code: _____

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

Occupation: _____ Employer: _____

Business Address: _____ City: _____ State: _____ Zip Code: _____

How did you hear about us? _____ Email: _____

MEDICAL ALERTS: _____

INSURANCE INFORMATION

Primary Coverage

Subscribers Name: _____ SS#: _____ - _____ - _____

Subscribers Employer: _____ ID# _____

Subscribers DOB: / / Patient's Relationship to Insured: _____

Insurance Company Name: _____

Secondary Coverage

Subscribers Name: _____ SS#: _____ - _____ - _____

Subscribers Employer: _____ ID# _____

Subscribers DOB: / / Patient's Relationship to Insured: _____

Insurance Company Name: _____

PLEASE READ THE FOLLOWING AND SIGN

Insurance will be filed up to two times as a courtesy to the patient. Any unpaid claims or charges insurance does not pay will ultimately be the patient's responsibility. I hereby authorize my insurance company to release payments to Gerlach Family Dentistry for services rendered. If missed appointments or less than 24-hour notice of cancellations become a problem, a \$50 missed appointment fee will be charged to the account. Deductibles, co-insurance and other payments are due day of service to eliminate billing problems. If a balance remains unpaid after 30 days, finance charges of 15% will be added to the account.

I have read, understand, and agree to the aforementioned policy.

Signature of person financially responsible for account

Date

Print Name