Patient's name____ Date ______________________

Date of birth ____________ Preferred name ____

Name of spouse ____

If a child, parent's name ____

Mailing address____ Apt # _______________

City_____________________________ State___________________ Zip _____________________

Phone: Home (_____)__________ Cell (_____)__________ Work (_____)__________ Ext.___________

E-Mail address ____

Employer____ Position ___________________

Business address ____

City____ State______ Zip_______________

Spouse's employer ____

Who may we thank for referring you? ____

Who is your general dentist at this time? ____

Emergency contact ____ Phone _______________________

Person responsible for payment of account ____
(name,address,telephone if different from above)

Primary Dental Insurance

Your dental insurance is through (check one):

__your employer __your spouse's employer __other

Employee's full name:

____

Employee's date of birth ____________________

Employer's name __________________________

Insurance name ___________________________

Insurance address _________________________

____

Employee ID#_____________________________

Group# ______________Union local #_________

Insurance company phone (____)______________

Social security # of policy holder______________

Secondary Dental Insurance (if you have dual coverage)

Your dental insurance is through (check one):

__your employer __your spouse's employer __other

Employee's full name:

____

Employee's date of birth ____________________

Employer's name __________________________

Insurance name ___________________________

Insurance address _________________________

____

Employee ID#_____________________________

Group# ______________Union local #_________

Insurance company phone (____)______________

Social security # of policy holder______________

1. We are not a participating provider in any dental plan; however, we will submit your insurance pre-treatment estimate to your insurance provider at your request.
2. If you do not wish to give us your social security number, you may choose to be a cash patient and pay at the time of service. We will provide you with a complete form to file your claim.
3. If you want us to file insurance on your behalf, please provide all requested insurance information before services are performed. We will collect an approximation of your portion at the time of service and file your insurance claim. After the insurance portion is paid, we will send a statement for any balance remaining. This balance will be due at receipt of statement.

Assignment of insurance benefits:

I hereby authorize payment directly to A. Cheria O'Neal DMD, MHS of any and all insurance benefits, and I authorize the release of information requested by the patient's insurance company.

Signature____ Date____________