

# Anderson Dental Care

## Personal Information

Name \_\_\_\_\_  
*last first middle initial*

Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Home Phone(\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Drivers License# \_\_\_\_\_ State \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse name \_\_\_\_\_ Spouse work phone(\_\_\_\_) \_\_\_\_\_

Parent/guardian name if patient is a minor \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Relation \_\_\_\_\_ Telephone(\_\_\_\_) \_\_\_\_\_

E-mail Address \_\_\_\_\_

*Who may we thank for referring you?* \_\_\_\_\_

To avoid any misunderstandings regarding your dental insurance, we wish our patients to know that all **professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees.** We will assist you in filing all insurance forms. Be aware that your insurance benefit may not cover treatment that is best for you. **Payment is due when services are rendered unless other arrangements have been made.** If you must change a scheduled appointment, please inform us as soon as possible.

**Acknowledgement of receipt of Notice of Privacy Practices and Consent for use and disclosure of health information.** I acknowledge obtaining a copy of Notice of Privacy Practices and I understand, that by signing this Consent, I am giving my consent to your use of my protected health information to carry out treatment, payment activities and health care operations.

**Signature of patient** \_\_\_\_\_ **Date** \_\_\_\_\_  
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time.

I hereby authorize Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of medication, and therapy that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatment or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. I understand that responsibility for payment for dental services provided in this office for me or my dependents is mine, due and payable at the time services are rendered. I agree to pay collection costs and/or reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit.

**Signature of patients or responsible party** \_\_\_\_\_ **Date** \_\_\_\_\_