WELCOME TO DRS. HERINGHAUS GENERAL DENTISTRY

THANK YOU FOR SELECTING OUR DENTAL TEAM!!!

TODAY'S DATE: _____

NAME: _____ Mr. Mrs. Ms. Dr.
First Middle Last

ADDRESS: _____
Street City State Zip

SS#: _____-_____-_____ DOB: _____ SEX: _____

HOME PHONE: _____ MARITAL STATUS: _____

CELL PHONE: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US?
Friend/Relative Website Google Facebook Yellow Pages Other _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ DOB: _____
ADDRESS: _____
RELATIONSHIP TO PATIENT: _____ SS#: _____
EMPLOYER NAME AND ADDRESS: _____
DENTAL INSURANCE COMPANY: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ DOB: _____
ADDRESS: _____
RELATIONSHIP TO PATIENT: _____ SS#: _____
EMPLOYER NAME AND ADDRESS: _____
DENTAL INSURANCE COMPANY: _____

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners.

FINANCIAL POLICY

Payment is due at time of service. We accept Cash, Personal Check, VISA, MasterCard, Discover, American Express and CareCredit.

Insurance Patients: As a COURTESY TO YOU, we will file your insurance claim provided that we are supplied with complete and correct information. CO-PAYMENT IS DUE AT TIME OF APPOINTMENT. In the event that your insurance company does not pay within a reasonable time period, you will be responsible for the full balance.

I authorize and request my insurance company (if applicable) to pay benefits directly to the doctor.
I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Failure to keep my account current will result in Drs. Heringhaus General Dentistry being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and attorney fees incurred in attempting to collect this account.

_____

Signature of Patient (or Parent/Guardian if Minor) Date

If patient is a minor: _____
Name of Parent/Guardian (Print)

_____
Address Phone #