Information update

PLEASE PROVIDE US WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE, SO WE CAN MAKE A COPY FOR OUR RECORDS.

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Email Address**: _____@_____

Social Security#:_____ **Do you receive emails?** Yes or No

Cell#:_____ **Do you receive text?** Yes or No

Home #:_____ **What is the best way to confirm your appointment?**

Work#_____EXT._____ Phone Call Text Message Email

Mailing Address _____

City _____ **State** _____ **Zip** _____

Emergency Contact Information: (Parent or legal guardian information if the patient is under 18)

Person to contact in case of an emergency:_____

Relationship to patient:_____ **Phone #**_____

Responsible Party Information:

Who is responsible for this account? _____ **Relationship to Patient?** _____

Responsible Party's Date of Birth _____ **SS #** _____

Place of Employment _____ **Work Phone Number** _____
Alternate Number _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **ID#**: _____

PATIENT IS RESPONSIBLE FOR OBTAINING ALL REFERRALS

I HEREBY AUTHORIZE ASSIGNMENT OF BENEFITS TO BE PAID DIRECTLY TO DR SHAMBURGER OF RESERVOIR SMILES DENTISTRY. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTILL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS AGREEMENT IS TO BE CONSIDERED VALID AS AN ORIGINAL. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICE WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL FOR ALL COINSURANCE AND DEDUCTIBLE COSTS, AS WELL AS ANY DOCTOR'S SERVICES WHICH ARE DETERMINED TO BE NON-COVERED OR DENIED. I AUTHORIZE MY PHYSICIAN TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY BILL. WE RESERVE THE RIGHT TO ADD A FINANCE CHARGE TO ANY PAST DUE ACCOUNT.

PATIENT/GUARDIAN SIGNATURE: _____