White Sands Family Dental

Patient name: ____________________________Preferred name: ____________________DOB____________
Mailing Address: _______________________________City: _____________State: ______ Zip: ____________
SSN: _______________ Gender: Female Male Marital status: Married Single Domestic Partner Minor child
Cell phone: _______________ Home phone: ______________Email address: __________________________
Whom may we thank for referring you to our Practice? ____

Primary Insurance

Primary Insured: ___________________________ DOB: __________________ SSN: ___________________
Address: ___________________________________ City: _____________State: ______ Zip: ________
Relationship to patient: Spouse Self Parent/Guardian Domestic Partner
Employer: ___________________Dental Insurance Company: ________________ ID #: ___________________

Federal Employees

Federal Employee Medical Insurance: BCBS ID: R______________ Basic/PPO GEHA ID: ________________

Secondary Insurance

Name: _______________________________ DOB: __________________ SSN: ___________________
Address: ___________________________________ City: _____________State: ______ Zip: ________
Relationship to patient: Spouse Self Parent/Guardian Domestic Partner
Employer: ______________________Insurance Company: ___________________ID #: _________________

Responsible Party (This must be filled out please)

Name: ________________________________ Relationship to patient: ___________________________
Address: ___________________________________ City: _____________State: ______ Zip: ________
DOB: _________________ SSN: ___________________ Daytime Phone: _______________________
Employer: _______________________________________ Work phone: _________________________

Insurance Policy

Your insurance contract is an agreement between your insurance company and yourself. We are not a party to that contract. Your complete insurance information must be presented at the time services are provided. All insurance co-pays and deductibles must be paid at the time of service. Insurance claims are electronically filled to expedite carrier payments, however, the patient is responsible for any unpaid charges due to exclusions and limitations written in per your plan provisions. I hereby authorize White Sands Family Dental to furnish information to my dental carrier concerning my treatment and I hereby assign to the doctors all payments for dental treatment rendered to myself or my dependents.

No-Show/ Late Cancellation/Late Charges

- There is a charge of $25.00 for not showing up for your scheduled appointments. This charge can be waived when you call to reschedule your appointment and notify us of the reason for the no show to the previous appointment. If your account shows repeated missed appointments or cancellations without 48 hours' notice, you may be asked to secure your next appointment with a deposit which will be forfeited if you do not show for the appointment that required a deposit
- I am aware that failure to keep this account current may result in the doctor being unable to provide additional dental services. In the case of default on payment of this account for any reason, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signed: ____ Date: ________________________________