Hillside Family Dental Care

Patient Information Form

Date: ___________________________

Name: ____ **Date of Birth**: __________________
Address: ____
Home Phone: _______________________ **Work Phone**: __________________**Cell Phone**: _____________________
Email: ____________________________________**How did you hear about our office?** _________________________

EMERGENCY CONTACT:
Name: ____ **Phone Number**: ___________________________
Relationship to Patient: ____

RESPONSIBLE PARTY FOR PAYMENT OF ACCOUNT**:**
Name: ____
Address: ____
Home Phone: _______________________ **Work Phone**: __________________**Cell Phone**: _____________________

INSURANCE INFORMATION:

PRIMARY
Name of Insured Person: ________________________
Relationship to Patient: _________________________
DOB of Insured Person: _________________________
SSN or Insurance ID of Insured Person: _____________
Employer: ___________________________________
Union or Local Number: _________________________
Name of Insurance Company: _____________________
Insurance Company Group Number: _______________
Insurance Company Phone Number: _______________
Insurance Company Address: ____________________

SECONDARY
Name of Insured Person: ________________________
Relationship to Patient: _________________________
DOB of Insured Person: _________________________
SSN or Insurance ID of Insured Person: _____________
Employer: ___________________________________
Union or Local Number: _________________________
Name of Insurance Company: _____________________
Insurance Company Group Number: _______________
Insurance Company Phone Number: _______________
Insurance Company Address: ____________________

INSURANCE AND PAYMENT:
Your dental insurance is a contract between you and your insurance company. We will help you obtain due benefits by preparing necessary claim forms. However, all professional services rendered are charged directly to the patient, and the patient is responsible for payment of all fees for services rendered. Initial: __________

Your co-insurance amount is due and payable at the time services are rendered. If this office is supplied with your insurance benefit information, we will make every effort to estimate your portion as accurately as possible. Any overpayment will be refunded to the appropriate party in a timely fashion. If there is still a balance due after your estimated portion and your insurance benefit is paid, then this office will bill the patient. Any remaining balance must be paid within 30 days from the date of the statement. Initial: __________

If you do not have insurance, payment in full is expected at the time services are rendered. Initial: __________

SIGNATURE ON FILE:
I authorize use of this form on all insurance submissions.
I authorize release of information to all my insurance carriers.
I understand that I am responsible for all fees for services rendered.
I authorize my insurance carrier to make payment directly to this office.

Signature of patient, parent, or guardian: _____________________________________ **Date**: _______________