

# Hillside Family Dental Care

## Patient Information Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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: \_\_\_\_\_