Dental Patient Personal & Insurance Information

(This form is Subject to the Privacy Act of 1974)

NAME *(Last, First, Middle Initial)*	Preferred Name (If different):	Date of Birth	AGE	MARITAL STATUS	Male/Female
HOME ADDRESS, CITY, STATE, ZIP CODE		SS#		Driver's License #	
E-MAIL ADDRESS		HOME / CELL PHONE		WORK PHONE / EXT	

Responsible Party Information

NAME *(Last, First, Middle)*	RELATIONSHIP	Date of Birth	SS#	Driver's License #	Male/Female
HOME ADDRESS, CITY, STATE, ZIP CODE			HOME / CELL PHONE	WORK PHONE / EXT	

Employment Information

EMPLOYER'S NAME	OCCUPATION	DO YOU HAVE INSURANCE Y/N?
EMPLOYER'S ADDRESS, CITY, STATE, ZIP CODE		

Primary Insurance Information

NAME OF INSURED *(Last, First, Middle)*	RELATIONSHIP	Date of Birth	SS#	Male/Female
INSURED ADDRESS, CITY, STATE, ZIP CODE				
INSURANCE PLAN NAME, ADDRESS AND PHONE:			ID#:	
			Group #:	

Emergency Information

IN THE CASE OF AN EMERGENCY, WHO MAY WE CONTACT?	PHONE #

Whom can we thank for referring you?

Insurance

This office will prepare insurance claims and assist in collecting from your insurance company. All money paid to the office will be credited to the patients account. In the event of an insurance over-payment or the insurance requests to be refunded, we will refund the insurance company. In the event your insurance does requests a refund, the patients account will be charged. This office cannot render services under the assumption that our charges will be paid by an insurance company. Patients who carry dental insurance must understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for all charges incurred, even in the event the procedure or procedures are deemed by your insurance as a non-covered procedure. This office and its Clinical Team follow the "Standard of Care" set by the State Board of Dental Examiners to assure you the best care possible. At the time of service, our office will estimate your portion based on benefit information given prior to your visit. You will be expected to pay the estimated portion at the time services are rendered. This portion is only an estimate. A statement will be sent every month to keep you aware of your account. After 90 days, you will be responsible for any remaining balance. All collection accounts will be held accountable for collection fees above initial balance.

Office Policies

All emergency dental services, or any dental services performed without previous financial arrangements must be paid in cash at time of services. Payment plans will be processed until balance is at zero status.

We respect your concern for your loved ones but due to the delicacy of our equipment and other patient privacies we request only the patient be present in the operatory. Additional family members must wait in our reception area.

We value your time and hope you will value ours. Our office reserves the right to charge for broken appointments without a 24 hour notice.

Authorizations

I do hereby authorize Concho Valley Family Dental or Dr. Fandel to release all information necessary to secure the payment of benefits. I authorize the use of this signature on file for all insurance claim submission whether manual or electronic.

I do hereby authorize dental services for my child including, but not limited to, X-rays, treatment and administration of anesthetics deemed necessary or advisable by the Doctor, whether or not I am present at the appointment when treatment is rendered (if applicable, please initial _____).

I have read the above office policies and payment conditions and agree to their content. My signature below represents my agreement.

I affirm the information I have given is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and cannot be released to anyone without my consent. It is my responsibility, as the patient, to notify the office of any changes to my medical status. I authorized Dr. Fandel and their Clinical Auxiliary to perform the necessary dental services I need.

Signature of patient (Or Legal Guardian If Patient is a Minor)	DATE