WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink and bring it with you at your scheduled appointment. If you have any questions or need assistance, please ask us – we will be happy to help.

1 *Personal Information*

Name: ____ Date: ______________________

Birth date: _____________________________ Wishes to be called: _____________________________

SS#: __________________________________ E-Mail: ____

0 Male 0 Female 0 Minor 0 Single 0 Married 0 Divorced 0 Separated

0 Widowed

Address: ____

City: ___________________________________ State: ____________ Zip: _________________

Employer: ____

Referred by: ____

2 *Responsible Party*

Who is responsible for this account?

Name: ____ Relationship to patient: ______________

Birth date: _____________________________

SS#: __________________________________ E-Mail: ____

Address: ____

City: ___________________________________ State: ____________ Zip: _________________

Employer: ____

Work phone: ____________________ Home phone: ___________________ Cell phone: _____________

3 *Telephone*

Home phone: _____________________ Cell phone: _____________________

Work phone: _____________________ Extension: _____________________

Where do you prefer to receive calls? 0 Home 0 Work 0 Cell

When is the best time to reach you? Time: ________________ Days: _________________________

In the event of an emergency, who should we contact? Name: _____________________________________

Relationship: ______________________ Work: _________________ Home: ________________________

4 *Dental Insurance Information*

Primary Insurance

Name of Insured: ____________________________________ Relationship to patient: _________________

Insured's birthday: ___________________________________ SS#: _________________________________

Employer: ____

Date employed: _____________________________________ Occupation: ___________________________

Insurance Company: ____

Group #: ____ Deductible: ___________________________

Amount already used: ________________________________ Max annual benefit: ____________________

5 Authorization and Release

I authorize the practice of David W. Hammer, DMD, PSC to release any information including the diagnosis and the records of any treatment, examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to David W. Hammer, DMD, PSC or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of patient, parent if minor, or guardian *Date*

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full is expected at each visit.

0 Cash 0 Personal check 0 Credit card 0 I wish to discuss the dental office's policy.

Late Charges

Any balance over 60 days old would be subject to a $2.50 billing fee for every month thereafter until paid in full. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.

David W. Hammer, DMD, PSC
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