Dentistry West

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(608)829-0101

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Internet ☐ Work ☐ Dental Insurance ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Emergency contact:

Consent for Services

I hereby give consent to allow Dentistry West and their employees to provide diagnostic and definitive dental treatment as determined by the prescribing dentist; this include taking dental x-rays and use of local anesthetic. I understand and acknowledge that any dental procedure comes with potential benefits, risks, and complications. I also understand that the dentist will review treatment recommendations and also provide alternative options for treatment.

I understand that Dentistry West will provide me with an estimate of cost for dental services that have been recommended. I also understand that all dental services rendered are billed to the patient and are the responsibility of the patient. Dentistry West will help prepare and file dental insurance claims on my behalf, any payments made by the dental insurance company will be applied to my account.

A service charge of 1.5% per month (18% per annum) may be charged for any account balances that exceed 60 days past due, unless alternative payment arrangements were made prior to services being rendered.

☐ * **I have read and consent to treatment provided by Dentistry West and agree to follow their financial policy regarding payment for services.**

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

Relationship to Patient:

Dentist's signature:

Signature _____ **Date** _____

Response Date: _____