WELCOME TO DENTISTRY OF BETHESDA

Date:_____

Patient Information

□ Mr. □ Mrs. □ Ms. □ Dr. Name:_____NickName:_____
Last First MI

Address:_____
Street Apt. #

_____
City State Zip Code

Home Tel #:_____Work #:_____Cell #:_____

Sex: □ Female □ Male Birth Date:_____ □ Married □ Single □ Child □ Other Soc.Sec #_____

Email:_____ Whom May we thank for Referring you:_____

Last Dentist:_____ Primary Care Dr.:_____

Who will be responsibility for your account?

□ Self □ Spouse □ Parent □ Other_____
(if self skip to next section)

Name:_____ SS #:_____ DOB:_____

Address:_____
Street City State Zip Code

Employer Name and Address:_____

Employer Tel. #:_____Drivers Lic. #:_____

Insurance Information

Name of Insured:_____DOB:_____

Insurance Company:_____Phone:_____

Employer:_____ Emp Address:_____

_____Emp Phone#:_____

ID #:_____Group #:_____Patients relationship to insured: □ Self □ Spouse □Child □ Other

Patient Name:_____

Secondary Insurance Information

Name of Insured:_____DOB:_____

Insurance Company:_____Phone:_____

Employer:_____ Emp Address:_____

_____Emp Phone#:_____

ID #:_____Group #:_____Patients relationship to insured: □ Self □ Spouse □Child □ Other

Financial Policy

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full at the time of the visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service or financial arrangements have not been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims in compliance with HIPAA standards.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ _____

Patient (guardian) signature Date

FOR OFFICE USE ONLY: