Thank you for trusting us with you dental care.
We promise to do our best to provide you with
The finest care available. If you have any
Questions please do not hesitate to ask.

PATIENT INFORMATION Date________________________

Name: _______________________________Birth Date _____________ Social Security #________________________
Home Phone: ___________________________ **Cell Number** _______________________________
Address: _____________________________________ City____________________ State _____ Zip ____________
E-Mail Address___________________________________
Sex M or F Age___________ Single Married Widowed Divorced Minor
Patient's or Parent's Employer______________________________**Work Phone**____________________________
Business Address_________________________________City________________State_____Zip__________
Spouse or Parent's Name_____________________________ Employer _______________ Work Phone______________
Referred By: _____________________________
In case of emergency please contact*:* _____________________________________ Phone: ______________________

RESPONSIBLE PARTY

Person Responsible for this Account _______________________________ Relation to Patient _______________________
Address: ____ Home Phone________________________
Street city-state zip
Birth date______________________ Employer __________________ Work Phone ____________________________
Currently a Patient in our Office: Y or N

INSURANCE INFORMATION:

Name of Insured____Relation to Patient_____________________________
Birth Date _________________________________ Social Security #______________________________________
Employer ____Work Phone _______________________________
Insurance Company_____________________________________ Group # __________________________________
Address ______________________________ City ____________________ State ________ Zip ______________

ADDITIONAL INSURANCE:

Name of Insured ____Relation to Patient_____________________
Birth Date __________________________Social Security # ____
Employer ____ Work Phone________________________
Insurance Company _____________________________________Group# _____________________________
Address _______________________________ City __________________ State ___________ Zip _________

ASSIGNMENT AND RELEASE

If, the undersigned have insurance with any insurance company, he/she assign directly to Dental Associates of Evansville P.C. all benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

MINOR/CHILD CONSENT

I, being the parent or guardian of _________________________________ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

PAYMENT

We make every effort to keep down the cost of your dental care. If you have insurance, we will file it for you as a courtesy to you, however any follow-up actions must be done by you. We know questions often arise on insurance matters. We encourage you to discuss such questions with our business staff. Please remember that NO insurance company attempts to cover all dental costs. It is your responsibility to pay any deductible, co-pay. Or any other balance not paid for by your insurance company. Delinquent accounts become due and payable on demand, plus legal rate of interest and collection costs including reasonable attorneys fees.

YOUR SIGNATURE:____________________