Herron Regional
DENTAL CENTER

Patient Information

First Name_____ Last Name_____ Middle Initial _____ Preferred Name_____

Address_____ City_____ State_____ Zip Code_____ SSN#_____

Birth Date _____ Age _____ Sex_____ Married___ Single___ Divorced___ Separated___ Widowed___

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Email_____ Drivers License _____

In case of an emergency who should be notified? _____ Phone _____

Whom may we thank for referring? _____ Pharmacy _____

Employment Status: Full time _____ Part time _____ Student Status: Full time _____ Part time _____

Responsible Party

First Name_____ Last Name_____ Middle Initial_____

Address_____ City_____ State_____ Zip Code_____ Birth Date_____

SSN#_____ Drivers License_____ Responsible party is also a Primary Policy Holder for patient_____

Primary Insurance Information

Name of Insured_____ Relationship to insured-Self___ Spouse___ Child___ Other___

SSN#_____ Birth Date _____ Employer _____

Insurance Company _____ Member ID _____ Group # _____

Address _____ City_____ State_____ Zip Code_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____, and assign directly to Herron Regional Dental Center all insurance 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 insurance submissions. I understand that if it becomes necessary to send my balance to be collected; collection fees, postage fees, and finance charges will be added.

_____ _____ _____

Responsible Party Signature Relationship Date