Heartland
FAMILY DENTISTRY

CONFIDENTIAL PATIENT INFORMATION

Preferred Name:_____ TODAYS DATE_____/_____/_____

NAME: Last _____First _____Middle_____ SEX **M☐ F☐**

STREET ADDRESS_____City_____State_____Zip_____

MAILING ADDDRESS_____City_____State_____Zip_____

SOCIAL SECURITY #_____-_____-_____BIRTHDAY_____AGE_____MARRIED? **Y☐ N☐**

PHONE Home Phone:(_____)_____-_____Work Phone:(_____)_____-_____Cell Phone:(_____)_____- _____

EMAIL ADDRESS_____

PREFERRED METHOD OF CONTACT (Check one) ☐Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Text

Other_____

By providing your number/email address, you authorize our office to contact you via the number/email provided.

RESPONSIBLE PARTY INFORMATION

IF THE SAME AS PATIENT INFORMATION —SKIP THIS SECTION

NAME: Last_____First_____Middle_____ SEX **M☐ F☐**

ADDRESS_____City_____State_____Zip_____

SOCIAL SECURITY #_____-_____-_____ BIRTHDAY_____AGE_____ MARRIED? **Y☐ N☐**

EMPLOYER_____OCCUPATION_____

PHONE Home Phone:(_____)_____-_____Work Phone:(_____)_____-_____ Cell Phone:(_____)_____- _____

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

INSURED'S NAME_____

INSURANCE COMPANY_____

INS. CO ADDRESS_____

CITY_____ST_____ZIP_____

INSURED'S EMPLOYER_____

INSURED'S SSN#_____-_____-_____ ID#_____

GROUP#_____

- **PLEASE GIVE A COPY OF THE CARD TO THE RECEPTIONIST**

SECONDARY DENTAL INSURANCE INFORMATION

INSURED'S NAME_____

INSURANCE COMPANY_____

INS. CO ADDRESS_____

CITY_____ST_____ZIP_____

INSURED'S EMPLOYER_____

INSURED'S SSN#_____-_____-_____ ID#_____

GROUP#_____

- **PLEASE GIVE A COPY OF THE CARD TO THE RECEPTIONIST**

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT_____RELATIONSHIP TO PATIENT_____

HOME PHONE (_____)_____-_____ WORK# (_____)_____-_____ CELL PHONE# (____)_____-_____

Consent

The undersigned hereby attest that the above information is complete and accurate. I authorize the Doctor to take X-rays, study models, and photographs. Or any other diagnostic aids deemed by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the dental office and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the dentist. Any payments received by the office from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fee incurred. I further understand that a rebilling fee will be added to any overdue balance. I also acknowledge that I have been offered a copy of

the office Notice of Privacy as required by law. I also understand that I can refuse parts of the consent by crossing out the sections that I disagree with but by doing so, the Dentist may refuse treatment.

PATIENT SIGNATURE (Parent if under 19) _____DATE_____/_____/_____