Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your entire dental healthcare needs, please take a few moments to tell us about yourself.

PATIENT INFORMATION (Confidential)

Name _____ *Birthdate* _____ *Home Phone* _____

Cell Phone _____ *E-Mail* _____ *S. S. #* _____

Address _____ *City* _____ *State* ___ *Zip Code* _____

If student, Name of School/College _____ *City* _____ *State* _____

Employer _____ *Work Phone* _____

Business Address _____ *City* _____ *State* _____ *Zip* _____

Whom may we thank for referring you ? _____

Person to contact in case of emergency _____

RESPONSIBLE PARTY (If other than patient)

Person responsible for this account _____ *Relationship to Patient* _____

Address _____ *City* _____ *State* ____ *Zip* _____

Home Phone _____ *Work Phone* _____ *S. S. #* _____

Employer _____ *City* _____ *State* ____ *Zip* _____

Is this person a patient of our practice? ☐ *Yes* ☐ *No*

INSURANCE INFORMATION

Policy Holder _____ S. S. # _____ Birthdate _____

Relationship to Patient _____ Employer _____ Group # _____

Employer Address _____ City _____ State ____ Zip _____

Insurance Carrier _____ Phone _____ Policy ID # _____

Address _____ City _____ State _____ Zip _____

Insurance Maximum _____ Deductible _____ Benefits used YTD _____

AUTHORIZATION AND RELEASE

- I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.
- I authorize Dr. Mugford to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners unless otherwise directed.
- ~~I authorize and request my insurance company to pay directly to Dr. Mugford insurance benefits otherwise payable to me.~~
- ~~I agree to be solely responsible for payments for any professional services rendered on my behalf or my dependants. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that any unpaid claims the carrier does not pay or any balances that extend beyond 90 days from the date of treatment will be assessed a finance charge of 1 ½ % (unless other arrangements have been made in writing)~~
- I will notify you of any changes in my health status or in the above information.

_____ _____

SIGNATURE DATE

_____ _____

PARENT (if minor) DATE