PARADISE
DENTAL PROFESSIONALS

Date _____ Patient Birth date _____

Patient's Name _____
Last First MI

If child, parent's name: _____How do you wish to be addressed _____

Single ___ Married ___ Divorced ___ Minor ___ Other ___

Address _____City _____ State _____ Zip _____

Home Phone _____ Cell _____Email Address_____

Employer _____Work Phone _____

Spouse/Parent Name _____Spouse Employer _____

Party Responsible for account _____Driver's License # _____

Preferred method of payment: Insurance ____ Cash ____ Credit Card ____

Other family members in practice_____

Social Security # Patient/Parent _____Social Security # Spouse/Parent _____

Emergency contact person _____Emergency Contact # _____

Whom may we thank for this referral? _____

Primary Dental Insurance Coverage

Employer _____

Employee Name _____ Date of Birth _____

Relationship to patient _____

Insurance Company _____

Insurance Address _____

Phone _____ Policy or Group # _____

Subscriber #/Social Security Number _____

Secondary Dental Insurance Coverage

Employer _____

Employee Name _____ Date of Birth _____

Relationship to patient _____

Insurance Company _____

Insurance Address _____

Phone _____ Policy or Group # _____

Subscriber #/Social Security Number _____

Consent:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclose of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____ Date _____