Patient Information Form

***Name:*_____ *Hm Phone:*_____*Cell Phone:*_____

***SS#*_____*Date of Birth:*_____*Wk Phone:*_____

Best Contact Method*(circle):* ***Home Cell Work E-mail*** ***Text Messaging OK?*** *(circle one)* ***YES NO***

***Employer*_____*E-mail address:*_____

***Home Address:*_____*City:*_____*Zip*_____

Spouse's Name: _____*Spouse Phone:*_____

***Emergency Contact:*_____ *Relationship:*_____ *Phone:*_____

Whom may we thank for referring you to us?

_____ ***Phone:***_____

***Insurance:*_____*Group#*_____*ID#*_____

***Insured's Name:*_____*SS#*_____*DOB:*_____*Employer*_____

*Who is responsible for this bill?*_____

I will be paying today by: Cash_____ Check_____ Credit Card_____ Need Payments_____

If I have dental insurance, I assign benefits otherwise payable to me under my insurance policy to this office. This is direct assignment of my benefits under this policy. ***I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.*** *After my dental insurance company has paid its portion of the dental services rendered to me at the office of Drs. David M. and Robert E. Fuchs, I hereby give my consent to that office to charge any outstanding balance to my credit card or bank. This balance may include deductibles and denials as well as non-covered services.*

*Credit Card#*_____ *Exp. Date:* _____ *Circle One: Visa MasterCard Discover*

Signature for card_____

Patient (or Responsible Party) Signature: _____ ***Date:***_____