New Patient Information

Patient **Date**_____

Name_____ ☐ Male

Address_____ ☐ Female

City_____ State_____ Zip_____

S.S. #_____ Home phone (___)_____ Work phone (___)_____

Date of Birth_____ I prefer to be addressed as_____

Name of dentist_____ Last visit_____

Email address_____ Referred by_____

Responsible Party

1- Name_____

Address_____

City_____ State_____ Zip_____

S.S. #_____ Date of Birth_____ Home phone(___)_____

Employers Name_____

Address_____

Work phone (___)_____ **Relationship to patient**_____

2- Name_____

Address_____

City_____ State_____ Zip_____

S.S. #_____ Date of Birth_____ Home phone(___)_____

Employers Name_____

Address_____

Work phone (___)_____ **Relationship to patient**_____

Insurance coverage

It is important that you understand that dental and accident insurance policies are an arrangement between the insurance carrier and you. Any amount authorized to be paid directly to the orthodontist will be credited to your account on receipt, and any over payments will be refunded to the appropriate party.

However, you must clearly understand and agree that all services rendered you are charged directly to you and you are personally responsible for payment. Payment for services rendered are due at the time of appointment unless prior arrangements are made with the business office.

In order to facilitate the correct and rapid processing for your insurance claim we need to have a completed insurance form on file. Please advise us of any insurance changes when applicable.

I hereby authorize payment directly to Kirk J. Anderton, D.D.S. M.S. any group dental payments from my insurance company otherwise payable to me, but not to exceed the charges shown. I understand I am financially responsible to said orthodontist for charges not covered by this assignment.

SIGNED (Responsible Party) _____

DENTAL INSURANCE

1-Name of carrier and plan_____

Address and phone#_____

Name of insured_____

2- Name of carrier and plan_____

Address and phone#_____

Name of insured_____

IT IS YOUR PERSONAL RESPOSIBILITY TO NOTIFY OUR OFFICE OF ANY INSURANCE CHANGES WHEN APPLICABLE.