

W E L C O M E

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 fill out this form completely (front and back) in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1. Personal Information

Date _____
Name _____ Wish to be called _____
 Male Female Minor Single Married Divorced Widowed
Address _____
City, State, Zip _____
Date of birth _____
Social Security Number _____
Employer _____ Occupation _____
Referred by _____

2. Responsible Party

Who is responsible for the account?
Name _____
Relationship to patient _____
Home Phone _____ Work Phone _____
Address _____
City, State, Zip _____
Date of Birth _____ Driver's License number _____
Social Security Number _____
Employer _____ Occupation _____

3. Telephone

Home Phone _____ Work Phone _____
Cell Phone _____
Where do you prefer to receive calls? Home Work Cell
When is the best time to reach you? Time _____ Days _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____
Home phone _____ Work Phone _____

4. Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's date of birth _____
Soc. Sec. # _____
Employer _____
Date Employed _____
Occupation _____
Insurance Co. _____
Group number _____
Employee/Cert. # _____
Insurance Co. Phone # _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Insured's date of birth _____
Soc. Sec. # _____
Employer _____
Date Employed _____
Occupation _____
Insurance Co. _____
Group number _____
Employee/Cert. # _____
Insurance Co. Phone # _____

5. Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I understand that any dental insurance contract is between my insurance company and myself, and that any charges that are incurred for services by Dr. David L. Raass, are due and payable by me at the time of service.

6. Financial arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card Master Card Visa

I understand that failure to pay my account or to make suitable financial arrangements to pay my account will result in my account being turned over for collections. Should it become necessary to take my debt to collection, I agree to pay all collection costs which includes but does not limit to collection agency fees, court cost, attorney fees and any other fees or cost for the collection of my account balance.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

Signature of patient or parent if minor _____