VALLEY DENTAL WORKS

Today's Date: _____

Patient Information

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____

❑ Male ❑ Female Birthdate: ___/___/___ Age: _____

Driver's License # _____

Home Address: _____

Apt/Condo #

_____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone: (___) _____ Pager: (___) _____

Work Phone: (___) _____ Ext: _____

Cell Phone: (___) _____

Text Confirmation: ❑ Yes ❑ No

Email Confirm Confirmation: ❑ Yes ❑ No

How did you find out about our office? Circle all that apply.

Doctor/Dentist Friend Internet Mailer Other: _____

Employer _____

Employer's Address: _____

_____
City State Zip

Length of employment: _____ Occupation: _____

When are the best times to reach you? _____ am _____ pm

Whom may we Thank for referring you?: _____

Person Responsible for Account/Spouse

Name: _____

Birthdate: ___/___/_____

Employer: _____

Work Phone:(___)_____ Home Phone:(___)_____

Relationship: _____

Billing Address: _____

_____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (___) _____

Policy # _____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____

Relationship: _____

Birthdate: _____/_____/_____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (___) _____

Group Number (Plan, Local or Policy #):

Insured's Name: _____

Relationship: _____

Birthdate: _____/_____/_____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

In the event of an emergency, whom should we contact?

Name: _____

Relation: _____

Work Phone: (____) _____

Home Phone: (____) _____

Patient Name	Date of Birth	Sex	Age
Patient Name	Date of Birth	Sex	Age
Patient Name	Date of Birth	Sex	Age
Patient Name	Date of Birth	Sex	Age
Patient Name	Date of Birth	Sex	Age
Patient Name	Date of Birth	Sex	Age

PATIENT INFORMATION

Please sign back.

PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PORTION UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Authorization and Release

I understand that if I have insurance, Valley Dental Works will prepare and submit my dental claim as a service to me. I also accept full financial responsibility for all charges whether or not they are covered by insurance.

I hereby authorize payment directly to Valley Dental Works of the group insurance benefits otherwise payable to me. I also authorize release of any information including the diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees.

Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 1.5% per month, or 18% annually. These additional fees will be applied to the unpaid balance at the end of the month.

Name (Please print): _____

Signature _____ **Date** _____

Consent

I consent to the diagnostic procedures as well as any and all forms of treatment by the doctor as she/he deems appropriate and/or indicated for my dental needs. I also authorize and request the administration of any anesthetics and radiographs as may be deemed necessary and advisable by the doctor. I consent to the doctor's use and disclosure of my records (or my child's records) to carry out treatment and obtain payment, and for those activities and health care operations that are related to treatment or payment. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate. My consent to disclosure of records shall be effective until I revoke it in writing. I understand that payment is due when services are rendered. 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 insurance company or payor of dental benefits.

_____ _____

Signature of Patient *(or Legal Guardian)* ***Date***