PATIENT ACQUAINTANCE FORM

Name _____ Birthdate ___ / ___ / ___

Address _____ City _____ State ____ Zip _____

Res. Phone _____ Cell _____ May we contact you at work ❒ yes ❒ no

Place of Employment _____ Employer Phone _____

Name of Spouse _____ Birthdate ___ / ___ / ___

Place of Employment _____ Employer Phone _____

DEPENDENTS	BIRTHDATE	DEPENDENTS	BIRTHDATE
_____	___ / ___ / ___	_____	___ / ___ / ___
_____	___ / ___ / ___	_____	___ / ___ / ___

PERSON RESPONSIBLE FOR ACCOUNT IF DIFFERENT THAN ABOVE:

Name _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

I give the office of Peterson Dental Associates PA, permission to release my information to the person listed as responsible for account. ☐ Yes ☐ No

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

I understand the office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made.

A monthly late charge of .66% per month (8% APR) will be charged to all account balances over 60 days past due. The late charge will remain in effect until the balance has been paid in full.

Signature _____ Date _____

In case of an emergency, who should we notify?

Name _____ Relationship _____ Cell _____

Address _____ City _____ State ____ Zip _____

Whom may we thank for referring you to our practice? _____

Name and address of previous dentist? _____

IF PATIENT IS A MINOR PLEASE COMPLETE

I give my permission to Dr. Thomas Peterson or Dr. Russell Peterson, and/or their designated assistant(s) to perform any and all dental techniques and procedures, including but not limited to the administration of nitrous oxide sedation and anesthetics on my minor child(ren) _____, whether or not I am present at the actual appointment when the treatment is rendered. I further agree to be financially responsible for all treatment rendered to the above named child(ren).

Signed _____ Date _____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM IF COVERED BY INSURANCE

INSURANCE INFORMATION

If you have insurance which may assist you with a portion of your account, please complete the following information:

Policy Holder Information **PRIMARY INSURANCE**

Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder Phone Number _____ Birthdate ___ / ___ / ___

Place of Employment _____

Name of Insurance Company _____

Insurance's Address _____ City _____ State _____ Zip _____

Group Number _____ I.D.# _____ Effective Date of Insurance _____

The above Insurance is Coverage for: ❒ Self ❒ Spouse ❒ Children ❒ All Family Members

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Policy Holder Information **SECONDARY INSURANCE**

Name _____

Address _____ City _____ State _____ Zip _____

Place of Employment _____ Birthdate ___ / ___ / ___

Name of Insurance Company _____

Insurance's Address _____ City _____ State _____ Zip _____

Group Number _____ I.D.# _____ Effective Date of Insurance _____

The above Insurance is Coverage for: ❒ Self ❒ Spouse ❒ Children ❒ All Family Members

INSURANCE RELEASE / PAYMENT FORM

The undersigned hereby authorizes the release of any information relating to all claims submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes Peterson Dental Associates PA to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim(s).

I, _____ hereby authorize _____ to pay and assign directly to Peterson Dental Associates PA, all insurance benefits, if any, otherwise payable to me for services described on the attached forms. I understand I am financially responsible for all charges incurred less any insurance benefit when received by and paid to Peterson Dental Associates PA. Authorization is hereby given to release all information necessary for the payments of said benefits.

Signed _____ Date _____