WELCOME to ANDERSON DENTAL!

PATIENT INFORMATION - CONFIDENTIAL

NAME:______________________________ Birthdate:______________

ADDRESS:______________________City/State:________________ Zip:__________

HOME #:________________ WORK #:________________ CELL #:________________

EMAIL:____

SS #: ________-________-________ (MARRIED) (SINGLE) (DIVORCED) (WIDOWED)

Spouse/Parent/Emergency Contact:________________________ Phone #:____________

Who may we thank for referring you?________________________

RESPONSIBLE PARTY

Who's responsible for this account? ______________________ Relation to pt:____________

INSURANCE INFORMATION – ***for NEW PATIENTS or CHANGE OF INSURANCE***

Insurance Co:______________________________ Phone #:______________________

Policyholder:______________________________ Relationship to patient:____________

Birthdate of Policyholder:____________________ SS # of Policyholder:______________

FEES and INSURANCE INFORMATION

- As a convenience to our patients, our office will submit claims for services to your insurance company. However, we require that any co-payments be paid at the time of service.
- Please keep in mind that your dental insurance plan is designed to share in your dental costs but it may not cover the total cost of your bill. **IT IS IMPORTANT FOR YOU TO UNDERSTAND THAT YOUR ACCOUNT IS YOUR SOLE RESPONSIBILITY.**
- We can provide an estimate of anticipated insurance payment for more extensive treatment plans; however, WE CANNOT & DO NOT GUARANTEE PAYMENT FROM INSURANCE CARRIERS.
- Please inform our office of any changes in your insurance, employer or personal information.

AUTHORIZATION & RELEASE – I authorize Dr. Jeffrey Anderson 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 health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. **I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.**

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Signature of Patient/Parent Date

(Revised 8/22/2022~cr)