Account Information

Patient Information:

Full Name: _____ Cell Phone: _____
Address: _____ Home Phone: _____
City: _____State:_____ Zip Code: _____ Work Phone: _____
Date of Birth: ____ / _____/_____ SS#: _____- _____ - _____ Email:_____

Medical Doctor: _____ Doctor's Phone:_____
In case of emergency, who should we notify? _____ Contact's Phone: _____

Account Information: Circle relationship to patient: *Self* *Spouse* *Parent* *Guardian* *Facility*

Full Name: _____ Cell Phone: _____
Address: _____ Home Phone: _____
City: _____State:_____ Zip Code: _____ Work Phone: _____
Date of Birth: ____ / _____/_____ SS#: _____- _____ - _____ Email:_____

Primary Dental Insurance:

Insurance Company Name: _____
Group Policy #:_____
Policy Holder's Name: _____
Date of Birth: ___ /_____/ ___ SS#: ____ - _____- _____
Employer:_____

Secondary Dental Insurance:

Insurance Company Name: _____
Group Policy #:_____
Policy Holder's Name: _____
Date of Birth: ____ / _____/_____ SS#:_____-_____ -_____
Employer: _____

Additional Information for Children Under 18: Circle who child lives with: *Mother* *Father* *Guardian*

Other Parent's Name: _____ Cell Phone: _____
Address: _____ Home Phone: _____
City: _____State:_____ Zip Code: _____ Work Phone: _____
Date of Birth: ____ / _____/_____ SS#: _____- _____ - _____ Email:_____

Guardian's Name: _____ Cell Phone: _____
Address: _____ Home Phone: _____
City: _____State:_____ Zip Code: _____ Work Phone: _____
Date of Birth: ____ / _____/_____ SS#: _____- _____ - _____ Email:_____

Authorization, Medical Release & Financial Agreement

I authorize Kai D Hart, DMD or Hart Dental Care to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health care providers.

I authorize the dental staff to perform necessary dental services for my minor/child (if applicable), including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

I acknowledge that payment is due at the time of service unless other arrangements are made, and understand that I am financially responsible for the payment of all services rendered on my behalf or on behalf of my minor child. I authorize my insurance carrier (if applicable) to pay directly to Kai D Hart, DMD, all insurance benefits which are otherwise payable to me. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I certify that the above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Kai D Hart, DMD or Hart Dental Care or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

I understand that should any legal action be required to collect unpaid balances, I will be responsible for any unpaid balance, interest, service fees, court costs and attorney's fees.

_____

Signature of Patient (Parent/Guardian if under 18) Date