ANACONDA DENTAL WORKS

Katherine S. Slocum DDS

Today's Date:			
Full Name:			
(First)	*(Middle)*	*(Last)*	
Birthdate:	Age:	Sex:	Marital Status:
Soc. Sec. No.		E-mail:	
Address:			
City:		State:	Zip Code:
Contact Phone Numbers:	Home:	Cell:	Message:
Employer:		Position:	
Business Phone:		How Long Employed:	
Person responsible for payment ***(if applicable)*** **:**			
	(First)	*(Middle)*	*(Last)*
Date of Birth:		Soc. Sec. No.	
Address:		Relationship to Patient:	
City:		State:	Zip Code:
Contact Phone Numbers:	Home:	Cell:	Work:
Emergency Contact Information:			
Full Name:			
(First)	*(Middle)*	*(Last)*	
Address:			
City:		State:	Zip Code:
Contact Phone Numbers:	Home:	Cell:	Work:

Whom may we thank for referring you today? ____

PLEASE NOTE: IF YOU WOULD LIKE US TO SUBMIT CLAIMS TO YOUR INSURANCE, ALL INSUANCE INFORMATION AND/OR A COPY OF YOUR INSURANCE CARD *IS A MUST*. IF YOU DO NOT HAVE THIS INFORMATION OR DO NOT WISH TO PROVIDE US WITH THIS INFORMATION, FULL PAYMENT FOR DENTAL SERVICES WILL BE YOUR RESPONSIBILITY AT TIME OF APPOINTMENT.

(Continue on the back)

INSURANCE INFORMATION (where applicable write, "same as above")

Do you have dental insurance? □**Yes** □**No** - If yes, please complete the following:

Name of Insured:		
(First)	*(Middle)*	*(Last)*
Relationship to patient:		
Insured's Birthdate:	Soc. Sec. No.	
Name of Employer:		
Employer Address:		
City:	State:	Zip Code:
Work Phone:	Date Employed:	
Insurance Company:	Group #:	Policy/ID #:
Ins. Co. Address:		
City:	State:	Zip Code:
Max. annual benefit $:	Deductible $:	

Do you have additional insurance? □**Yes** □**No**

Permission to share Protected Health Information:

I, ____________________, give my permission, until revoked, to share my dental and medical records
patient or guardian

with the following persons:

Signature: **Date:**

FINANCIAL AGREEMENT AND AUTHORIZATOIN FOR TREATMENT *(PLEASE READ)*

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier 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, promptly upon presentment thereof; unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for dental services rendered to me or my dependents, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. I understand that nonpayment of any account could result in a finance charges with an annual rate of 18% and or a rebilling fee.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for collection thereof. (A copy of this assignment is as valid as the original.)

The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or her agent to make credit investigation, including employment verification.

______________________________ ______________________

Signature of patient (or parent if minor) **Date**