BEECHCROFT DENTAL

Welcome! Thank you for selecting our dental team to provide you with the best possible dental care!

Name_____ __ Preferred Name_____

Address_____City:_____State:_____Zip_____

SSN_____DOB_____ Male Female

Home Phone_____ Work Phone_____

Cell Phone_____Email_____

Marital Status Single Married Divorced Widowed Separated

Emergency Contact_____Relationship_____Phone_____

Insurance-Primary

Subscriber Name_____ Relationship to Patient_____ Subscriber DOB_____

Subscriber ID/SSN_____ Subscriber Employer_____

Insurance Company Name_____ Employer _____

Insurance-Secondary

Subscriber Name_____ Relationship to Patient_____ Subscriber DOB_____

Subscriber ID/SSN_____ Subscriber Employer_____

Insurance Company Name_____ Employer _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Herrick Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____

Relationship_____ Date_____

Privacy Practices Acknowledgement

I have been offered a copy of this office's Notice of Privacy Practices.

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Signature of Patient, Guardian, or Representative Date