



BEEHCROFT 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.

Signature of Patient, Guardian, or Representative _____ **Date** _____