

PATIENT INFORMATION**William L. Patterson, DDS**

Today's Date ____/____/____

Patient's Name _____ Sex M F Date of Birth ____/____/____
First MI LastHome Address _____ Phone # (____) _____
Street City State Zip Home #

Social Security # _____ E-mail address _____

 Single Married Widowed Divorced Are you a full time student? Yes No School Name _____Other Phone Numbers (____) _____ (____) _____ (____) _____
Work # Mobile # Pager #Employer _____
Name Address City State ZipHas any member of your family been treated in our office? Yes No If so, who? _____

How did you hear about our office? _____

Who should we contact in case of emergency? _____ (____) _____
Name Relationship Phone # Spouse Parent if minor _____ (____) _____
Name Address Phone #Person Responsible for Account _____ SS# _____
Name Relationship**DENTAL INSURANCE INFORMATION**Subscriber's Name _____ Relationship to Patient _____
First MI Last

Subscriber's SS# and/or ID # _____ Subscriber's Date of Birth ____/____/____

Subscriber's Employer _____
Name Address City State Zip

We will need to copy your insurance card or please provide us with the following information so we may verify coverage:

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (____) _____ Group # _____ Local Union # if any _____

FOR OUR PATIENTS WITH DENTAL INSURANCE: Your dental benefits help offset the investment of getting quality dental care performed on you and your family and it is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. Please be aware that your coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. Please understand that any assistance concerning what or how much coverage you have, whether by phone or mail, is for reference only and should not be your only basis for proceeding with treatment. We do not base our treatment recommendations on what the insurance company will cover but rather what the best treatment is for you. We will assist you in any way that we can (including electronic claims submission). In addition, because of the inconsistencies in secondary insurance benefits, we do not consider the secondary benefits when figuring your portion of the charges. We will gladly give you what you need to file your secondary claims yourself and the payments from your secondary can be assigned to you. Once your primary carrier has paid, any difference will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment 60 days after the claim, the remaining balance will be due and payable by you and subject to interest charges. Thanks for your understanding.

- I have dental insurance and I agree to pay for any and all treatment either: prior to treatment (for discount) day services are provided
- I have dental insurance and would like to have this office file insurance claims for me. I understand this office does not send statements after insurance payments and I must have either a cash credit on account or a major credit card authorization on file (secured). I authorize this office to debit my credit card account for charges not reimbursed to this office by the insurance company.
- I have insurance and I prefer to pay for my treatment on the day services are provided and let the insurance company reimburse me.
- I would like to know more about alternative payment plans.

I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services rendered. In the event it should become necessary to place your account in the hands of an attorney or collection agency, you will be responsible to pay all costs of collection, including attorney's fees.

Patient, Parent or Guardian Signature _____ Date ____/____/____