WEST MOBILE DENTAL CARE

Patient Information

*Full Name_____*Date of Birth_____

*Email Address_____

*Address_____*City_____*State____*Zip Code_____

*Telephone: Home_____*Work_____ *Mobile_____

*Social Security #_____*Driver's License#_____

Occupation_____Employer_____

Gender_____Age_____Height_____Weight_____

*Emergency contact name: _____*Phone:_____

*GUARDIAN OR RESPONSIBLE PARTY

Full Name_____Relationship_____

Address_____ _____

Home Phone_____*Work_____*Mobile_____

*INSURANCE POLICY

Name of Insured_____

Date of Birth_____ Social Security_____

Employer_____ Insurance Company_____

Address_____

Policy#_____Group#_____Phone#_____

Do you have additional dental insurance? Yes No If yes, please notify our staff.

We are happy to assist you in understanding and filing your insurance for most dental procedures. Please remember your insurance is a contract between you, your employer, and your insurance company. Please understand that we cannot speak on their behalf. We will gladly act as an advocate but cannot be responsible for settling any disputed claims or coverage. We require payment of patient's estimated portion at the time of treatment. Our office policy states that you are solely responsible for your bill. If we do not receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.

_____ _____ _____

Patient Name (Please Print) Patient |Parent or Guardian Signature Date