PETTY DENTAL

Your Home for Beautiful, Healthy Smiles!

***Patient's Name*: Last_____, First_____, Middle _____**

Name you would like to be called: _____ Date of Birth: ___ / ___ / _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work phone: _____ Home Phone: _____

Email Address: _____If a student, name of school: _____

Employer:_____Occupation/Position: _____

Gender: M_____ F_____ Marital Status: Single _____, Married _____, Divorced _____, Widowed _____

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EMERGENCY CONTACT:

Name: _____ Relation to patient: _____

Cell Phone: _____Work Phone: _____ Home Phone: _____

Address (if different from above): _____City:_____

State: _____ Zip Code: _____

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***PERSON RESPONSIBLE FOR PAYMENT*: (if other than the patient above)**

_____ Relationship to Patient:_____

Place of Employment: _____ Birthdate: ____/____/_____

Cell Phone:_____ Work Phone: _____ Home: _____

Address (if different than above): _____

City: _____ State: _____ Zip Code: _____

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AUTHORIZATION OF CARE AND PAYMENT FOR PATIENT

- **I consent to treatment needed or desired for the above-named patient. This may include, but is not limited to: Medications, Dental procedures, X-rays, Photographs and/or other studies performed by Dr. Petty, his hygienists, or assistants.**
- **I acknowledge full responsibility for payment of all charges for dental services, materials and/or lab fees. I agree to pay my portion AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE with the Treatment Coordinator. I understand that any account considered delinquent may be subject to billing charges, collection costs and/or attorney's fees.**

Signature: _____Relationship to Patient _____ Date: _____

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How did you hear about us? Google Reviews: _____ Facebook: ____ Website: ____ Building/Sign: _____

Your Family: _____ Friends: _____Doctor: _____

THIS PAGE IS *ONLY* IF YOU HAVE DENTAL INSURANCE

Is Patient covered by a Secondary Insurance policy? Yes_____ No _____ If yes, please print another copy of this page or ask our team member for an additional insurance sheet for the secondary policy.

1. Who is the EMPLOYER that provides the insurance? _____

   Location of where they work: _____

2. Full Legal Name of Employee/Subscriber of the insurance: _____

   Relation to patient: _____ Their SSN: _____-_____-_____ Their DOB: ____/____/_____

3. Address (if different from patient's): _____

   City: _____ State: _____Zip: _____

4. Phone numbers same as patient's? Yes _____ If different, please provide below:

   Their Cell Phone: _____Work Phone: _____Home Phone: _____

5. Their MARTIAL status: Married _____Single _____ Divorced _____ Widowed _____

Please provide your insurance card(s), so a copy can be made. If you do not have a card, please provide:

Name of Dental Insurance Company _____

Subscriber/Member ID: _____ Group #: _____ Plan #: _____

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It is important for you to read this entire section.

Dental insurance is a benefit provided by employers to their employees. All benefit amounts and deductible rules are solely determined by the contract agreement between your employer and the insurance company. The dentist has **no** part in this process.

As a professional courtesy to our patients, our staff will file your insurance form for you. Our office has not signed any network contracts, but we make every effort to help you utilize your benefits by providing estimates of what your insurance might pay.

a) For companies that will mail us the check, **payment for YOUR deductible and copay is expected at the time of your appointment.** We will be glad to provide this estimated amount to you in advance of your appointment so you will know how much is expected.
b) Some insurance companies will not send the check to our office since we are not in their network, but will mail it to you. For those companies, we ask that you pay the full amount at the time of the appointment.

- I understand that Petty Dental is not in network with my insurance company.
- To the extent permitted by applicable law, I authorize release to my dental insurance carrier any information and documentation relating to claims for payment and/or any request for any pre-treatment estimate without any further authorization in the future.
- I authorize payment directly to Petty Dental from my insurance company.

Signature: _____ Date: _____

(if other than patient)
Person Completing the form: _____

Relationship to patient: _____