

BEND DENTAL GROUP

Patient Information

Date: _____

Please answer each question completely. All information is considered confidential.

Last Name: _____ First Name: _____ MI: _____

Prefer to be addressed as: _____ Date of Birth: _____ Age: _____

Social Security #: _____ Email: _____

Home Phone: _____ Work or Mobile Phone: _____

Mailing Address: _____

Patient employed by: _____ Present Position: _____

Business Address: _____

For minors, please list parents' or guardians' names: _____

Emergency Contact: _____	NAME	PHONE NUMBER	RELATIONSHIP
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Person responsible for payment of account: _____

Relationship to patient: _____ ODL#: _____

Home Phone: _____ Work or Mobile Phone: _____

Mailing Address: _____

Place of Employment: _____ Present Position: _____

Business Address: _____

How did you hear about Bend Dental Group?

_____ Personal Referral* _____ Phone Directory _____ Print Advertisement

* Whom may we thank for referring you to our office? _____

Release Information: Please read the following and sign below.

- I authorize Bend Dental Group to release any medical or dental information to my dental insurance company as required in order to process my insurance claims. I further authorize that insurance benefits be paid directly to Bend Dental Group.
- I authorize the use of my radiographs, photographs, or videotape of my case for use by Bend Dental Group in presentations or publications.
- I have read and understand the Financial Agreement, and understand that payment for dental services is due at time of services unless other financial arrangements are made with the Office Coordinator.

Signature: _____ Date: _____

*** PLEASE COMPLETE DENTAL INSURANCE INFORMATION ON REVERSE SIDE **

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DENTAL INSURANCE INFORMATION

Please Note:

As a courtesy to our patients, we will submit insurance claims electronically for processing. Please note that insurance benefits vary greatly, and it is your responsibility to know what services are included in your plan. Some plans provide only partial coverage of dental treatment, or exclude coverage for certain services. Any costs incurred beyond the insured amount are the responsibility of the patient and/or responsible party.

Primary Insurance

Insurance Company: _____ Phone: _____

Mailing Address: _____

Name of Subscriber:: _____ Subscriber #: _____

Group Name: _____ Group #: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____ Phone: _____

Mailing Address: _____

Name of Subscriber:: _____ Subscriber #: _____

Group Name: _____ Group #: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

*** Please bring your insurance card to your dental appointment. ***