Slidell Family Dental Care
Patient Information

TODAYS DATE: ____________________

Welcome! Please fill al information out to the best of your ability. This helps us understand you and helps facilitate insurance collection. Thank you.

PATIENT INFORMATION:
LAST NAME: ____________________ FIRST NAME: ____________________
Patient is: Child Single Married Divorced Widowed Sex: Male/Female
Address: (Street no P.O. Box)____________________
City: ____________________ State: ______ Zip: ____________________
PHONE: (HOME) ____________________ **(WORK)** ____________________
(CELL) ____________________
EMAIL: ____________________
SS# ____________________ (Date of Birth) ____________________
How did you hear about us: Friend/Family ______________ **Phone Book-Location-Sign**

INSURANCE AND RESPONSIBLE PARTY INFORMATION:
Insured or Responsible Party: Name____________________
SS# ____________________ (Date of Birth) ____________________
Policy # ____________________ Group # ____________________
Insurance Name: ____________________ PHONE: ____________________
Address: ____________________
Employer: ____________________ Address: ____________________

EMERGENCY INFORMATION
Spouse's Name:____________________ (Date of Birth)____________________
Employer: ____________________ Work # ____________________
Name of nearest relative not living with you: ____________________
Relationship: ____________________ Complete Address: ____________________
Phone # ____________________

Our office is a non-partcipating provider for insurance carriers for the following:
HMO/PPO practices tend to use inferior materials and laboratories to reduce their overhead therefore: we do not participate in any of these plans. Our office prides itself in offering the latest and most up to date technology available. We have recently added a new laser to our practice. The laser will allow many procedures to be done virtually pain free. We offer only the best materials and laboratories. Our services are anything but usual and customary.
TO HAVE ANY "BILLING" OR INSURANCE FILED FOR YOU BY THIS OFFICE PLEASE READ AND SIGN THE FOLLOWING PARAGRAPHS
I hreby authorize this office to release or obtain any information which may be necessary to determine benefits to be paid on my behalf. I authorize payment to be made directly to Slidell Family Dental Care for dental treatment rendered.
Signature____________________ **Date**____________________

ALL FEES ARE THE RESPONIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY. AS A COURTESY TO YOU OUR OFFICE WILL FILE YOUR INSURANCE CLAIM FOR YOU. HOWEVER, SHOULD THE BALANCE NOT BE PAID IN 45 DAYS AFTER THE SERVICE IS RENDERED, THE OUTSTANDING BALANCE IS YOUR RESPONSIBILITY. I ALSO UNDERSTAND THAT IF MY ACCOUNT IS FORWARDED TO COLLECTIONS THAT ALL COLLECTION AND ATTORNEY FEES WILL BE ADDED TO MY PAST DUE BALANCE.

SIGNATURE: ____________________ **DATE:** ____________________