BEND DENTAL WELLNESS

New Patient Form

Legal Name: _____ Birthdate: ___/____/_____

Preferred Name: _____ Gender: _____ SSN: _____

Home/Billing Address: _____

Home phone: _____-_____-_____ Cell phone: _____-_____-_____

Email address:_____

Occupation: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Under Age 18

Emergency Contact Information

Name: _____ Relationship: _____

Primary Number: _____-_____-_____ Work Number: _____-_____-_____

Insurance and Financial Information

Primary:
Subscriber's Name: _____ Subscriber's Birthdate: _____/_____/_____

SSN # _____-_____-_____ Contact Number: _____-_____-_____

Insurance Provider: _____ Policy # _____

Group # _____
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Secondary:
Subscriber's Name: _____ Subscriber's Birthdate: _____/_____/_____

SSN # _____-_____-_____ Contact Number: _____-_____-_____

Insurance Provider: _____ Policy # _____

Group # _____
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Assignment & Release of Information

You may discuss my healthcare with:
Health Care Providers: ☐Yes ☐ No Insurance Companies: ☐Yes ☐ No

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) in the making of videotapes, photographs, and x-rays of my dental care treatment (collectively “My Images"), (5) my dentist's use of My Images in scientific papers, demonstrations, and/or presentations, without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the “Uninsured Costs”) in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

Signature (Patient/Guardian) _____ Date: _____/_____/_____