WELCOME WAUSHARA DENTAL ASSOCIATES, S.C.

PATIENT INFORMATION

Name: _____
Last *First* *MI*

I prefer to be addressed as: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

Date of Birth: _____ Sex ☐ M ☐ F

Social Security #: _____

Driver's License #: _____

Mailing Address: _____

City _____ State ____ Zip Code _____

E-mail Address: _____

For confirmation of appointments and company information only. We take your privacy very seriously.

Home Phone: (____)_____

Cell Phone: (____)_____Work: (___)_____

Can we reach you at your work number? ☐ Yes ☐ No

Employer: _____

Emergency Contact: _____

Relationship: _____

Telephone: (___)_____Work: (___)_____

ACCOUNT INFORMATION

Person Responsible for the Account

Name: _____

Relation to Patient: _____

Billing Address: _____

City: _____State: _____ Zip Code: _____

Social Security #: _____ D.O.B.: _____

Telephone: (___)_____ Work: (___)_____

PREFERRED METHOD OF CONTACT

Please choose one:

☐ E-mail ☐ Text ☐ Call

Circle One: Home or Cell

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Company:_____

Subscriber Name:_____

Subscriber D.O.B.:_____

Insurance Co. Phone #:(___)_____

Subscriber's Employer:_____

Group #:_____

Subscriber ID or Social Security #:_____

Patient's Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Child

Secondary Insurance (if applicable)

Insurance Company:_____

Subscriber Name:_____

Subscriber D.O.B.:_____

Insurance Co. Phone #:(___)_____

Subscriber's Employer:_____

Group #:_____

Subscriber ID or Social Security #:_____

Patient's Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Child

AUTHORIZATION

To my knowledge, the above information is correct. I hereby consent to any examinations, x-rays, diagnostic procedures, tests and/or treatment the doctor may prescribe. I understand if I refuse recommended treatment, I will be asked to sign off on the proposed service(s) thereby releasing the provider(s) from responsibility. I authorize release of any information, including diagnosis and the records of any treatment or examination given to me, to third party payors and/or other health practitioners as required and wish to assign benefits to Waushara Dental Associates. I give permission to use e-mail, text, post card or voice mail for communication purposes. I am responsible for any amount not covered by my insurance. I understand that payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that appointments broken or cancelled less than 24 hours' notice may result in a charge.

Patient/Guardian Signature:_____ Date:_____