Creekwood Dental Arts

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Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Driver's License Number: _____

Driver's License State: _____

Whom may we thank for referring you to our practice?

Employment

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Subscriber and/or Parent/Guardian Information

This page ONLY needs to be completed if the insurance subscriber is OTHER than the patient AND/OR you are the parent/guardian of the patient.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Consent for Services and Financial Policy

☐ * **I understand that responsibility for payment for services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other financial arrangements have been made. I understand that this office will prepare any insurance claim forms, will assist in making collections from insurance companies, and will credit such collections to my account. I authorize insurance benefits to be paid directly to the doctor. I also understand that it is my responsibility to pay in fully any balance due on an insurance claim over 75 days old. I understand that a 1.5% service charge (18% per annum) will be added to unpaid balances exceeding 90 days. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.**

Name of patient, parent or guardian completing these forms: *

_____

_____

Relationship to patient: *

◯ Self ◯ Parent ◯ Guardian ◯ Spouse ◯ Other

Response Date: ____/____/_____