WELCOME

Patient Name:_____

□ Married □ Single □ Child

Date of Birth:_____ Social Security # _____
(required for dental insurance verification)

Address:_____

_____
City State Zip

Cell :_____ Home Phone:_____ Work Phone:_____

Email:_____

Emergency Contact:_____Phone:_____

How did you hear about our office? _____

We may take study models and before/after photos of face, jaw and teeth for dental records, communication with other healthcare professionals, dental research, dental education including demonstrations or lecturing, and marketing materials in print/online. Patient information is confidential.

I give Henrickson Dental consent to the above statement and understand I may revoke my consent at any time and I will not be compensated, financially or otherwise for my authorization.

Please initial here for YES:_____ Here for NO:_____

Primary Dental Insurance:_____
Relationship to insured:_____
Insured Name:_____Date Birth:_____
Group #:_____Subscriber Id:_____

Secondary Dental Insurance:_____
Relationship to Insured:_____
Insured Name:_____Date Birth:_____
Group #:_____Subscriber ID:_____

- I understand Henrickson Dental will bill my dental insurance provider on my behalf and if in network, I authorize payment directly to Henrickson Dental otherwise payable to me.
- I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual fee for services, and that I am financially responsible for payment in full of all accounts regardless of estimated insurance benefits written or verbal.
- I understand that my payment is due at the time services are rendered and agree to pay reasonable collection and/or attorney fees should my account default.

Signature of Patient, Parent or Guardian Date