Welcome

Patient Information

Patient Name: _____ **Date:** _____

Patient Information

Street Address _____
City/State _____ Zip Code _____ Home phone _____
Work phone _____ Date of Birth _____ SS# _____
If patient is a full-time student, name of school _____
Employer _____ Address _____
_____ City/State _____ Zip Code _____
In case of emergency, who should be notified? _____ Phone _____
Relationship to patient _____ Driver's License State & Number _____
Whom may we thank for referring you? _____

Primary Insurance

Policy Holder _____
Relation to Patient _____ Date of Birth _____
Address (if different than patient) _____ City _____
State _____ Zip Code _____ Policy Holder employed by _____
Address _____ City/State _____ Zip _____
SS# _____ Work Phone _____
Insurance Company _____ Group Number _____
Subscriber # _____
Insurance Company Address _____ City/State _____
Zip Code _____ Phone _____

Secondary Insurance

Additional (Secondary) Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No
Policy Holder _____
Relation to Patient _____ Date of Birth _____
Address (if different than patient) _____
City/State _____ Zip Code _____
Policy Holder employed by _____
Address _____ City/State _____ Zip Code _____
SS# _____ Work Phone _____
Insurance Company _____ Group Number _____
Subscriber # _____ Insurance Company Address _____
City, State _____ Zip Code _____ Phone _____

Change in Insurance

Insurance Coverage Change – **Primary change___ Secondary change___ (please check)**

Date _____ Policy Holder _____
Relation to Patient _____ Date of Birth _____
Address (if different than patient) _____
City _____ State _____ Zip Code _____
Policy Holder employed by _____
Address _____ City/State _____ Zip Code _____
SS# _____ Work Phone _____
Insurance Company _____ Group Number _____
Subscriber # _____
Insurance Company Address _____ City/State _____
Zip Code _____ Phone _____

ADA.

_____

Signature - Person Responsible for Account Date

J508 To reorder call (800) 947-4746

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ and assign directly
Name of Insurance Company(ies)
to Doctors Taft and Taft all benefits, if any, otherwise payable to me for all services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Doctors Taft and Taft to release all dental information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Signature

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and
Name of minor/child
authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by Dr. Taft, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature of Insured/Guardian

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor /child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date Signature of Insured/Guardian

In the event that I do not have insurance coverage, I will be responsible to Doctors Taft and Taft for all fees and services rendered for treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I acknowledge that payment is due at the time of treatment, unless other arrangements are made.

_____ _____
Date Patient's Signature/Parent/Guardian

* A 5% interest may be added to accounts 60 days past due