McKenzie
DENTAL CENTER

Date_____

Patients Name:_____ **Date of Birth:**_____ **Female** ☐ **Male** ☐
Last First Initial

Dental Insurance Coverage

***If a Child*: Parents Name** _____ Employee Name_____

Who's responsible for this account?_____ Relationship to patient_____ DOB_____

Residence - Street _____ Employers Name_____

City _____ **State**_____**Zip** _____ Name of insurance company_____

Cell# _____**Home#** _____ Address_____

SSN#_____ ID#_____ G#_____

Driver's License #_____

Dental Insurance 2nd Coverage

Email:_____ Employee Name_____

Emergency Contact_____ Relationship to patient_____ DOB_____

Emergency contact #_____ Employers Name_____

_____ Name of insurance company_____

Where did you hear about our office? Address_____

☐ Family/Friend_____ ID#_____ G#_____

☐ Internet site ☐ Mail ☐ Billboard ☐ Other

Marital Status ☐ Single ☐ Married ☐ Widowed

How would you like to be reminded of your appointments?

☐ Text ☐ Phone call ☐ Email

Welcome!

Consent:

I consent to diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or child's records) to the following person's _____

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer. I attest to the accuracy of this page

PATIENTS OR GUARDIANS SIGNATURE _____ Date _____