Gentle Dentistry of Columbus

PERSONAL INFORMATION

Name: _____ **Preferred Name:** _____

Home Address: _____

City: _____ **State:** _____ **ZIP:** _____

Date of Birth: _____ **Age:** ___ **Sex:** _____ **SSN:** _____

Phone Number: _____ **email:** _____

Employer: _____ **Work Number:** _____

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone Number:** _____

INSURANCE INFORMATION

Policy Holder: _____ **Relationship to Patient:**_____

Primary's DOB: _____ **Primary's SSN:**_____

Member ID: _____ **Group #:**_____

Employer Name:_____

Name of Insurance Company:_____ **Phone # of Insurance Company:**_____

Address to Send Dental Claims To:_____

I understand that it will be held in strict confidence and it is my responsibility to inform this office of changes in medical status. As the patient, there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services.

I certify that I am covered by the insurance listed above and I assign these dental insurance benefits to Gentle Dentistry of Columbus. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Gentle Dentistry of Columbus may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

To the best of my knowledge I have answered every question completely and accurately.

Patient/Guardian Signature: _____

Date: _____