PATIENT INFORMATION (CONFIDENTIAL)

First Name Date_____

Last Name Date of Birth

Address

City, State and Zip

Home Number Cell Number

Work Number Texting: Yes or No

Soc. Sec. # Employer

Marital Status

Email address

DENTAL INSURANCE INFORMATION

Name of Insured Relationship to patient

Birthdate Soc. Sec. #

Name of Employer

Employer Address

Insurance Co Phone Number

Group/Policy #

Member ID #

Do you have secondary Insurance?

Your insurance plan is a contract between your employer and the insurance company. All patients are financially responsible for their accounts. The insurance company is responsible to the patient. Specific questions should be directed to your insurance carrier or your employer.

Most insurance plans don't cover all dental expenses. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by their insurance company.

I authorize Jerry L. Clore, D.M. D. to contact my insurance company carrier or its representative to determine the extent of my dental benefits. I also authorize Jerry L. Clore, D.M. D. to disclose information to any organization/insurance carrier that may be responsible under contract to my responsible party or me for payment of incurred charges for dental services. This information will be provided when required, to assure that treatment or services provided are both necessary and appropriate. For contracting insurance carriers, I assign benefits payable directly to Jerry L. Clore, D.M. D. for services rendered. I also agree that a $50.00 fee may be charged to all accounts 90 days past due and for appointments failed or cancelled with less than 24 hours notice.

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney's fees and costs of collection in the event of default

Signed:_____ Date:_____