

DATE: \_\_\_\_\_

PATIENT NAME LAST	FIRST	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP
HOME PHONE ( )	WORK PHONE ( )		
CELL PHONE ( )	E-MAIL ADDRESS		

Best method of reaching you \_\_\_\_\_

If patient is a dependent, complete the following:

- Yes  No Is patient covered by dental insurance?
- Yes  No Is patient a dependent according to IRS standards?       Yes  No Is the patient disabled?
- Yes  No Does patient attend college FT?      Name and location of college \_\_\_\_\_

(Pick method of payment)

Payment:  Cash     Check     Credit     Debit

Driver's License # \_\_\_\_\_

Referred by:

Friend     Union     Newspaper     Flyer     Insurance Co.     Website     Other \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY	PHONE
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### INSURANCE INFORMATION (must be completed in full)

Please note that if you have any other dental insurance plans you must use both plans to coordinate benefits. The information provided will determine which carrier is the primary and which is secondary.

	PRIMARY	SECONDARY
Name of Insured		
Address		
Phone Number	( )	( )
Date of Birth		
Social Security Number/Alt Id		
Employer Name		
Employer Phone	( )	( )
Dental Insurance (Family, Individual)		
Group Number/I.D. Number		
Medical Insurance Carrier		
Union Name/Local Number		
Are you Hourly or Salary?		

To the best of my knowledge, the information provided is accurate. In the event that there are any changes in my current insurance plans, I will provide that information to Fair Lawn Dental Associates. I understand that failure to provide such information may cause delays in processing or payment of my claims and I agree to pay if they are not paid timely as a result of such failure.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### NOTIFICATION OF RESPONSIBILITY & SIGNATURE AUTHORIZATIONS

I agree to make payments as services are rendered. I understand that if for any reason my dental insurance does not make expected payment or if my insurance is terminated, I will be responsible for the TOTAL FEE.

I hereby authorize Fair Lawn Dental Associates to execute in my name all payment application forms for treatment. The determination of treatment rendered by Fair Lawn Dental Associates shall be conclusive.

Signed \_\_\_\_\_ Date \_\_\_\_\_



Recall Information

Receptionist \_\_\_\_\_

Account Number: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

1. Change of Name: \_\_\_\_\_

2. Change of Address: \_\_\_\_\_

3. New Phone Number: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

4. Completed Change in Computer: \_\_\_\_\_

Employment and Insurance Change

Insured: \_\_\_\_\_ D.O.B. \_\_\_\_\_

New Employer: \_\_\_\_\_

Address: \_\_\_\_\_

New Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

I.D./Group Number: \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_\_

Terminated Insurance: \_\_\_\_\_

Secondary Insurance

Insured: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_\_

Family Members Covered: All ( )

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_