PECAN PARK FAMILY DENTISTRY

12335 Hymeadow Drive Suite 200 Austin, TX 78750 • (512) 250-2424

WELCOME!

PATIENT INFORMATION

Name: ____________________ Preferred Name: ____________ Date:__________

Email: ______________________________ Male / Female

Address: ____________________ City: __________ State: ______ Zip: ________

Home Phone: ______________ Work: ______________ Cell: ______________

Date of Birth: ______________ Age: ________ Marital Status: Single / Married / Divorced / Widowed

Social Security No.: ______________ Driver's License No.: ______________

Person Responsible for Account: ______________ Phone No.: ______________

Address (if different from above) ______________________________

Emergency Contact: ______________ Phone No.: ______________

Address: ____________________ City: __________ State: ______ Zip: ________

Family Members Who Are Also Patients Here: ______________________________

INSURANCE INFORMATION

Subscriber Name (if different from patient): ______________ Employer: ______________

Insurance Carrier: ______________ Subscriber's Date of Birth: ______________

Business Address: ______________ City: __________ State: ______ Zip: ________

Group No.: ________ Subscriber's SSN: ________ Dual Coverage? YES NO HSA or FSA Account? YES NO

How did you hear about us?______________________________

CONSENT

I authorize the dentist and staff to perform necessary diagnostic procedures and treatment for comprehensive and appropriate dental care.

I authorize the release of my (or my child's) pertinent medical/dental information to my insurance company for the purpose of submitting insurance claims and receiving payment for completed dental work.

I authorize the release of my (or my child's) medical/dental information to another dentist or healthcare professional when related to my dental treatment.

I understand that payment in full is due at the time services are rendered. This includes any portion of my balance that insurance is estimated not to cover.

I recognize that the amount I am told insurance will cover is only an estimate. I agree to be responsible for the remainder of services not paid by insurance. This includes any procedure that is denied completely by the insurance company.

I understand that Pecan Park Family Dentistry requires at least 24 hours of notice for all appointment cancellations. If I am unable to give 24 hours of notice, I will be billed $40 for the rescheduled or missed appointment.

I certify that the above information is complete and correct.

Patient's signature: ______________________________ **Date:** ______________