Drs. Brazel, Zunger and James, LLP

Patient's Name ____ **Date of Birth** _________________________

Last First

If Child: Parent's Name _______________________________

Residence – Street _____________________________**City** _____________ **State** _________**Zip** _____________

Telephone: Home __________________ **Bus.** ___________________ **Cell #** _______________________________

Marital Status: S M D W **Spouse's Name** ____

Patient/Parent Employed By ____

Patient/Parent SSN _________________________ **Spouse/Parent SSN** _____________________

Whom may we thank for this referral ____

Emergency Notification (Name & Tel # of nearest relative **not** living with you)____

PRIMARY DENTAL INSURANCE

Employee Name ____ **Date of Birth** __________________________

Employer Name & Addess ____

Name of Insurance Co. ____

Address ____

Telephone ____

Policy #____ **Group#**____

Social Security No. ______________________**Member ID NO.** __________________**Relation to Patient:** ______

SECONDARY DENTAL INSURANCE

Employee Name ____ **Date of Birth** _________________________

Employer Name & Address ____

Name of Insurance Co. ____

Address ____

Telephone ____

Policy # ____ **Group #** ____

Social Security No. _____________________ **Member ID No.** __________________**Relation to Patient:** _______

My consent to disclosure of records shall be effective until I revoke it in writing.

- I consent to the 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 my 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 authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits, if any, may be less than the actual bill for services, and that I am personally responsible for payment in full. By signing this statement, I agree to be responsible for payment for services not paid by my dental care payor, if any.
- I further understand that all responsibility for payment for dental services provided in this office for me or my dependent(s) is mine, due and payable at the time services are rendered unless other arrangements have been made.
- I understand that there is a $10 bank fee for returned checks. The check must be picked up personally and cash must be paid to cover the check and the fee.
- I understand that there is a $13.95 fee for accounts sent to collection.
- I attest to the accuracy of the information on this page.

PATIENTS'S OR GUARDIAN'S SIGNATURE ____

DATE ____