METROPARK DENTAL ARTS

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us - we will be happy to help.

Date _____mm/dd/yy_____
SS# / SIN _____
Patient's Sex ❒ F ❒ M

Patient Information (CONFIDENTIAL)

Name_____ Birthdate_____mm/dd/yy_____ Home Phone (___) _____
Address_____ City_____ State_____ Zip_____
Email_____ Cell Phone (___) _____
Do you prefer to receive calls/messages at your: ❒ Home ❒ Work ❒ Cell Phone ❒ Email ❒ Other (___) _____
Check Appropriate Box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated
If Student, Name of School/College _____ City_____ State_____ ❒ Full Time ❒ Part Time
Patient or Parent/Guardian's Employer_____ Work Phone (___) _____
Business Address_____ City_____ State_____ Zip_____
Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone (___) _____
Whom May We Thank for Referring You?_____
Person to Contact in Case of Emergency (not living with you)_____ Phone (___) _____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____
Address_____ Home Phone (___) _____
Email_____ Cell Phone (___) _____
Driver's License #_____ Birthdate_____mm/dd/yy_____ Financial Institution_____
Employer_____ Work Phone (___) _____ SS#/SIN_____
Is this Person Currently a Patient in our Office? ❒ Yes ❒ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at time of treatment.
❒ Cash ❒ Personal Check Credit Card: ❒ VISA ❒ MasterCard ❒ Discover ❒ I wish to discuss the office's payment policy

Insurance Information

Name of Insured_____ Relationship to Patient_____
Birthdate_____mm/dd/yy_____ SS#/SIN_____ Date Employed___mm/dd/yy___
Name of Employer_____ Union or Local #_____ Work Phone (___) _____
Address of Employer_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____ Policy/ID #_____
Ins. Co. Address_____ City_____ State_____ Zip_____
DO YOU HAVE ANY ADDITIONAL INSURANCE? ❒ Yes ❒ No

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved by financial coordinator.
This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____ mm/dd/yy
Signature of patient (or parent/guardian if minor) *Date*