Advanced Cosmetic and Implant Dentistry of Maryland.

PATIENT INFORMATION

Welcome to our office. Please provide the following information. It is important to our records and your health.
Note: we ask for Social Security information because many insurance companies track patients with this number.

Patient name (Mr./Mrs./Ms/Dr.) ____
Today's Date ____/____/______Email Address: ___________________________________
Date of Birth: ____/____/____ SSN:________________
Home/Mailing Address: ____
City: ____________________________State:________ Zip Code: __________
Home Phone: ____________________ Work/Cell Phone:_______________________
Occupation(s): _________________________Employer:_________________________

How did you find out about us?: Ad(list) ____________ Friend(whom)_ _________ Our Website________
Delta Dental _______ Google_______________ Yelp___________SPU Ad________Other (list)______________

Person Responsible for payment of account (if other than self):____

☐ **NO INSURANCE**

INSURANCE – PRIMARY COVERAGE
Employee Name_______________________________
Employee SocSec # ________________________________
Employee Date of Birth ____/____/____
Employer ____________________________________
Insurance Co. _________________________________
Address_____________________________________
Phone ______________________________________
Group or Policy # _____________________________

INSURANCE- SECONDARY COVERAGE
Employee Name__________________________________
Employee SocSec #__________________________________
Employee Date of Birth ____/____/____
Employer _______________________________________
Insurance Co. ____________________________________
Address____
Phone ____
Group or Policy #_________________________________

Insurance reimbursement is a contract between you and your insurance company. Please read and review our insurance consent form carefully.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit term and policy. Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for the claim.

Signed: ____
Parent (or Guardian) Signature _______________________________________ ***Date:*** ________________________