COCKEYSVILLE DENTAL

PATIENT INFORMATION					
			Cell		
			E-Mail		
Last Name	Title	First	Middle		
Address	City		State	Zip	
Home Phone	Work Phone	Social Security Number	Date of Birth	Sex	
Marital Status	Maiden Name		Height	Weight	
If Full Time Student - School	School City				
Employer	Occupation		Years Employed		
Employer's Address	City	State	Zip		
Closest Relative's Name	Relationship	Relative's Phone			
Whom may we thank for referring you?					

PRIMARY GUARANTOR First Person Financially Responsible For Account					
Last Name	Title	First	Middle	Pt's. Relationship	
Address	City	State	Zip		
Home Phone	Work Phone	Social Security Number	Date of Birth	Sex	
Employer	Occupation		Years Employed		
Employer's Address	City	State	Zip		
If This Guarantor's Insurance Covers This Patient:	Is This Insurance Coverage Primary Or Secondary For This Patient?				
Insurance Company Name	Address				
Plan or Group Name and Number	Deductible	Max. Benefits	Benefit Year		

SECONDARY GUARANTOR Second Person Financially Responsible For Account					
Last Name	Title	First	Middle	Pt's. Relationship	
Address	City	State	Zip		
Home Phone	Work Phone	Social Security Number	Date of Birth	Sex	
Employer	Occupation		Years Employed		
Employer's Address	City	State	Zip		
If This Guarantor's Insurance Covers This Patient:	Is This Insurance Coverage Primary Or Secondary For This Patient?				
Insurance Company Name	Address				
Plan or Group Name and Number	Deductible	Max. Benefits	Benefit Year		

IF YOU HAVE DENTAL INSURANCE: We will help you determine your benefit coverage and assist you with your claims. Professional care is provided to you, our patient, and not to an insurance company. The insurance company is responsible to the patient, and the patient is responsible to the doctor. Insurance plans and their benefits differ greatly as to deductibles, exclusions, plan maximums, benefit limitations, benefit schedules, and patient co-payment amounts.

Due to information requirements for claims submittal, I hereby authorize release of any information relating to my claims.

Signature of Patient or Parent/Guardian ✘ _____ Date _____

FOR ALL PATIENTS: In consideration for services rendered to the above patient, I hereby accept responsibility for all charges on this patient's account, regardless of any insurance coverage available.

Signature of Person(s) Financially Responsible ✘ _____ Date _____

✘ _____ Date _____