

Welcome!

The following confidential information is important for the dentist to know in planning your dental care.
Please answer each question as completely as possible. Thank you.

Patient Information

Name _____ Birthdate _____ SS# _____

How would you like to be addressed? _____

Address _____ City _____ St. _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ ext _____ Cell Phone _____

E-mail Address _____

Preferred methods of appointment confirmation: ___ call (circle one: home/work/cell) ___ email ___ text

Employer _____ Occupation _____

Check Appropriate Box: ___ male ___ female ___ single ___ married ___ other

Spouse's name _____ Birthdate _____

Employer _____ Work Phone _____

Whom may we thank for referring you to our office? _____

Person to contact in case of emergency _____ **Phone** _____

Account Information (Please present your insurance card or claim form at your visit.)

Primary Dental Insurance _____ Group # _____

Name of Policyholder _____ Birthdate _____ Social Security # _____

Secondary Dental Insurance _____ Group # _____

Name of Policyholder _____ Social Security # _____

The information I have provided to Eden Prairie Dental Care is correct to the best of my knowledge.

I give my consent to Eden Prairie Dental Care to discuss with my spouse, family members, or guardian information to facilitate my treatment and/or payment on my account.

I hereby authorize Eden Prairie Dental Care to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-determination of treatment plan fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Eden Prairie Dental Care for the services rendered to me by either the doctor or the staff. I understand that I am ultimately responsible for the total cost of my services.

I understand 24 business hours notice are needed when cancelling or rescheduling an appointment.

I agree to be responsible for payment of all services rendered on my or my dependent's behalf, and I understand finance charges may be added to remaining balances over sixty (60) days. I am aware that there will be an additional charge of 40% of my bill in the event my account is turned over to a collection agency and the Credit Bureau of Minneapolis/St. Paul.

I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient/Guardian _____ **Date** _____