DR. DAVE'S HEALTHY SMILES FOR KIDS & YOUNG ADULTS

Dave L. Hippensteel, DMD

Patient's Name ______________________________ Nickname ________________ Date____________

Date of Birth_______________ Male ____ Female____ Social Security #_________________________

Address: ______________________________City:______________________State;______Zip:_________

Home Phone:_______________ Cell Phone :__________________Cell Carrier_______________________

How did you hear about our office?____

With whom does the patient live_________________________ School______________________________

Text appt. reminders: __**YES** __**NO**--Email reminders __**YES** __**NO** Email:__________________________

Child's Physician___________________________________ May we consult with him/her ____**YES** ___**NO**

Dental Insurance ______________________________Subscriber_________________________

Father's Name: _____________________________
DOB: ____________________________________
Address: _________________________________
City, State, Zip: ___________________________
Home Phone No.: ___________________________
Social Security No.: _________________________
Employer: ________________________________
Business Phone No.: ________________________
Dental Insurance: __________________________
ID#: _____________________________________
Group # (if applicable): _____________________

Mother's Name: _____________________________
DOB: ______________________________________
Address: ___________________________________
City, State, Zip: _____________________________
Home Phone No.: _____________________________
Social Security No.: ___________________________
Employer: _ ________________________________
Business Phone No.: __________________________
Dental Insurance: ____________________________
ID#: ______________________________________
Group # (if applicable): _______________________

Names and address of person responsible for child other than above:

____

This office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. Dental insurance is a contract between the patient and the insurance company for reimbursing the cost of dental services. It is not a contract between the dentist and the insurance company.

I understand that I am financially responsible for all services rendered by the Dentist. I understand any co-payments, deductibles, and/or procedure cost not covered or denied by my insurance company, (including coverage termination prior to the date services are rendered) are my responsibility. I certify that the insurance(s) listed here represents all coverage(s) in place as of today. This Dental office is authorized to fill out and/or assist me to complete any and all insurance forms pertaining to services rendered. A Finance Charge may be added to my account balance outstanding over sixty days (60) and I will be responsible for any collection costs or legal fees to effect collection of a defaulted account balance.

I authorize & request my insurance company to pay directly to the dentist those benefits otherwise payable to me. I give my consent to needed dental services & use of proper & acceptable methods to complete same & accept responsibility for payment of services performed for_____________________________.
(Patient's Name)

____

(Signature of Person Responsible for Payment of Account) (Date)