Welcome to Eagle Family Dentistry!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible. If yo have any questions, or we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name_____(If child, parent/guardian name)_____
Last name First Name

Birthdate_____Sex_____Age_____Social Security #_____

Home Address_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Email_____Driver's License #_____

Employer_____Occupation_____How long there_____

Employer Address_____City_____State_____Zip_____

Spouse's Name(or other parent/guardian)_____Social Security #_____

Spouse's Employer_____Occupation_____How long there_____

Spouse's Employer Address_____City_____State_____Zip_____

If patient is a student: Name of School/College_____City&State_____FT or PT_____

How did you hear about our practice?_____

Primary Insurance:

Name of Insured_____

Birthdate_____Relationship to patient_____

Address (if different from patient)_____

Dental Ins Co._____

Social Security #_____Subscriber ID#_____

Group, Contract, Local or Union #_____

Additional Insurance:

Name of Insured_____

Birthdate_____Relationship to patient_____

Address (if different from patient)_____

Dental Ins Co._____

Social Security #_____Subscriber ID #_____

Group, Contract, Local or Union #_____

Co-payments:

To accept insurance, we now debit co-payments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check:

Card Type_____Card #_____Exp. Date_____Name on Card_____

In case of emergency:

Name and city of primary care physician_____

Someone we may contact, not living with you_____Contact #_____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I understand that I am responsible for all changes whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary.

I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

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

Signature(patient or responsible party)_____Date_____