

WILLAMETTE DENTAL PATIENT INFORMATION

Date _____

OFFICE USE _____ SSI# _____ MB _____ PROV _____ ATYPE _____ LOC _____ CHART # _____ STATS _____

PLEASE PRINT

PATIENT INFORMATION:

NAME _____ Male Female Married Single
FIRST MI LAST NICKNAME

DRIVER'S LICENSE NO. _____ STATE _____

Dr. Mr. Mrs. Miss Ms.

EMERGENCY CONTACT:

NAME _____ RELATIONSHIP TO PATIENT _____

STREET ADDRESS _____ HOME PHONE _____

RESPONSIBLE PERSON:

For balance insurance will not cover: _____
NAME

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____ WORK PHONE _____

Whom may we thank for referring you to our office?

NAME _____ ADDRESS _____ PHONE _____

In order for Willamette Dental Group, Willamette Dental Insurance, Inc., Willamette Dental of Washington, Inc., or Willamette Dental of Idaho, Inc. (collectively referred to as Willamette Dental) to process your insurance claims, we will need your signature to release payment.

I authorize release of any information relating to any claim for services rendered to me or my dependents.

I assign and request your company to pay directly to Willamette Dental insurance benefits otherwise payable to me or my dependents.

I understand I am financially responsible to Willamette Dental for charges not covered by this assignment. If my indebtedness for such charges is placed with an attorney or collection agency for collection, I agree to pay Willamette Dental such collection costs, including attorney fees.

SIGNATURE (INSURED NAME) _____ PRINT NAME _____ DATE _____