

Lincoln Village Dental

Responsibility Party/Account Information

Thank you for choosing our dental office! The following forms will help us accurately process the financial aspects of your dental services in the same manner that you expect our staff to accurately provide excellent dental care. If you have any questions regarding these forms please ask one of our team members. We look forward to establishing a long-term trustworthy and satisfying relationship.

PATIENT INFORMATION:

First Name _____ Middle Name _____ Last Name _____

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

Name of school/college attending _____ Location _____ Units _____

ACCOUNT HOLDER:

First Name _____ Middle Name _____ Last Name _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Address _____

Account Holder E-mail Address _____ Check here if you **do not** prefer statements by e-mail

Driver's License # _____ Birth Date ____ / ____ / ____

Account Holder Social Security Number _____

INSURANCE BENEFIT COVERAGE (A)

Policy Holder First Name _____ Middle Name _____ Last Name _____

Policy Holder Social Security Number _____ Birth Date ____ / ____ / ____

Relationship to Patient:

Self Spouse Parent/Guardian Step-parent Domestic Partner Other _____

Employer _____ Employer Phone () _____

Insurance Company Name _____ Group # _____

Teamster Name and/or Local Number _____ Insurance Carrier Phone () _____

Mail Claims to: _____

INSURANCE BENEFIT COVERAGE (B)

Policy Holder First Name _____ Middle Name _____ Last Name _____

Policy Holder Social Security Number _____ Birth Date ____ / ____ / ____

Relationship to Patient:

Self Spouse Parent/Guardian Step-parent Domestic Partner Other _____

Employer _____ Employer Phone () _____

Insurance Company Name _____ Group # _____

Teamster Name and/or Local Number _____ Insurance Carrier Phone () _____

Mail Claims to: _____

AUTHORIZATION

I have reviewed this questionnaire and answered the questions accurately and to the best of my knowledge. I agree to notify the office of any changes in address, phone number or dental (insurance) benefit status. I understand that responsibility for **ALL DENTAL SERVICES** provided by Lincoln Village Dental, for my signified dependents or myself, is mine; *due and payable at the time of services*. I understand this office will assist me with insurance benefit recovery by providing a statement of dental services and documentation for services rendered by this office. I understand that any discrepancies in payment by my insurance carrier and the billed fees for dental services are my responsibility. I further understand, it is my responsibility to know my insurance coverage and my eligibility to collect any benefit coverage during the year. I hereby authorize payment directly to my dentist by my dental benefits carrier (if any) otherwise payable to me. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this dental service debt. I understand, at my request, I have a right to know the fee for dental services before this office provides such services. I further understand that a *two-working day* notice is required for appointment changes; to avoid a \$100 per hour charge. We're aware emergencies may happen, so please telephone our office immediately of any scheduling changes that may be necessary.

Signature of Patient _____ Date _____

(Or Guardian if under 18 years of age)