James S. Kimbrell, DMD
Patient Update

Patient Name _____

Address _____

Home Phone_____ Cell Phone_____

Current Dental Insurance Carrier _____

Who is the policy holder? _____

Has your medical history changed since your last visit?
If yes, please explain _____

_____

PLEASE MAKE SURE WE HAVE YOUR CORRECT AND UPDATED INSURANCE INFORMATION. WE WILL FILE YOU INSURANCE CLAIM FOR YOU, HOWEVER IF YOU HAVE NOT PROVIDED CORRECT INSURANCE INFORMATION AND YOUR CLAIM IS REJECTED, WE WILL NOT REFILE CLAIM AND YOU WILL BE RESPONSIBLE FOR PAYMENT. WE WILL NOT BE FILING CLAIMS FOR SECONDARY INSURANCE.

_____ _____
SIGNATURE OF PATIENT **DATE**