Habersham Family Dental

Office Of Patrick McShane D.M.D, P.C.

Name:			Legal Name:
Mailing Address:			911 Address:
City:	State:	ZIP:	County:
Home Phone:	Work Phone: Ext.		Email Address:

How may we confirm appointments with you?
Email? : ☐ YES ☐ NO **Cell Text?** : ☐ YES ☐ NO **Call Home?** : ☐ YES ☐ NO

Cell Phone Number:

Date of Birth: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Soc. Security #:

Full Time Student? ☐ Yes ☐ No
Where?

Spouse name:

Employer: Occupation:

Business Address: City, State, ZIP:

Whom may we thank for referring you? / How did you hear about us?

RESPONSIBLE FOR ACCOUNT

Name of person responsible for account: Relationship:

Address:
(If different from above)

Phone:

City, State, ZIP: Soc. Security #: Date of Birth:

DENTAL INSURANCE INFORMATION

Name of Policyholder/Subscriber: Relationship to Patient:

Policyholder Soc. Security #: Date of Birth:

Employer Name: Employer Phone:

Address of Employer:

Insurance Company: Group #: Policyholder/Subscriber ID #:

Do you have additional dental insurance? ☐ Yes ☐ No

Secondary Insurance Information:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child in compliance with HIPAA laws.

I authorize and request my insurance company to pay insurance benefits directly to the dentist otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on me or my dependents behalf. I understand that any unpaid balance (over 30 days) may be subject to finance charges or billing charges.

Signature: Date: