Lewisville Dental
Implants & Braces

PATIENT INFORMATION

Name _____
Last *First* *M.I.* *Preferred Name*

Gender: M F Marital Status: _____SSN:_____ DOB:_____

Driver's License#: _____E-mail Address: _____

Patient Address_____
Street *City* *State* *Zip*

Home Phone #: _____Work: _____Ext:_____Other:_____

Which is best for confirmation? E-MAIL _____Home#_____Work#_____Cell#_____

Who may we thank for referring you to our practice?_____

Emergency Contact : _____
Name *Phone #*

RESPONSIBLE PARTY INFORMATION (If Different From Above)

Name _____
Last *First* *M.I .* *Preferred Name*

Gender: M F Marital Status: _____ SSN: _____ DOB:_____

Driver's License #: _____E-mail Address: _____

Patient Address_____
Street *City* *State* *Zip*

Home Phone #: _____Work:_____Ext:_____Other:_____

Dental Insurance (If any)
Insurance Company _____ Insurance Phone: _____

Subscriber's Name :_____ DOB: _____

SSN or I.D.# _____Relationship to Patient : _____

Subscriber's Employer :_____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s) have insurance coverage with _____and assign directly to Lewisville Dental -Implants and Braces and its affiliates all insurance benefits, if any , otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not they are paid for by insurance. I authorize the use of my signature on all insurance submissions. Please be advised that due to nature of our business, we require a 48-hour cancellation notice. The above named office and /or doctor may use my health care information and may disclose such information to the above named insurance and company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed and balance is paid-in-full or two years from the date signed below.

_____ _____ _____
Signature of Patient/Parent or Guardian Please print name of Patient/ Parent or Guardian Date