MINSTER DENTAL CARE

PATIENT INFORMATION *(Please Print)*

First | Middle Initial | Last | Date of Birth

Preferred Name *(If Different from Legal Name)*

Male / Female *Biological Gender* | Male / Female / Other *Identified Gender* | Social Security #:

Mailing Address | City, State and Zip Code

Home Phone Number | Cell Phone Number

E-Mail Address *(For Office Communication)*

Patient is: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Patient's Employer | Work Phone

Is there dental coverage through this employer: Yes / No If yes, complete information on the back.

Spouse's Name & Employer | Work Phone

Is there dental coverage through this employer: Yes / No If yes, complete information on the back.

PARENT INFORMATION *(For Dependent Children)*

Mother's Name | Father's Name

☐ Single ☐ Married ☐ Divorced ☐ Separated | ☐ Single ☐ Married ☐ Divorced ☐ Separated

Mailing Address *(If different than patient)* | Mailing Address *(If different than patient)*

City, State and Zip Code | City, State and Zip Code

Social Security # | Date of Birth | Social Security # | Date of Birth

Contact Phone Number | Contact Phone Number

DENTAL INSURANCE INFORMATION: ***(PLEASE PROVIDE CARD FOR COPYING)***

CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE

PRIMARY INSURANCE		SECONDARY INSURANCE	
Name of Insured / Policy Holder		Name of Insured / Policy Holder	
Relationship to Patient	Insured DOB	Relationship to Patient	Insured DOB
Employer	Social Security #	Employer	Social Security #
ID#	Group #	ID#	Group #
Insurance Company		Insurance Company	
Insurance Company Address		Insurance Company Address	

CONSENT

I understand that I am financially responsible for all charges incurred and have seen the office policy form. I understand a minimum of $2.00 per month or 2% of my total balance finance charge will be assessed on all unpaid balances over 30 days. I authorize Minster Dental Care permission to use and disclose health/personal information about me (or said minor) for treatment, payment, and healthcare operations. If patient is a minor, authorization is hereby granted for Minster Dental Care to provide dental care for said minor.

Signature of Patient (over 18) Or Parent / Guardian ______________________ Date ______________

Relationship to Patient: ______________________

FEDERAL TRUTH IN LENDING STATEMENT

In the event that your insurance applies services to a deductible, determines a service is not payable due to frequency, is not covered, or is disallowed for any reason the balance will become the responsibility of the patient or responsible party. In the event this occurs you will be billed for the services not covered for any reason, rejected, or applied to the deductible. I understand that if any insurance plan has an adjustment from the provider for services and the amount required by the insurance is either more or less than what was estimated at the time of service by the provider, I may be billed an additional amount after insurance benefits and any adjustments are determined. I have read and understand that the services provided may be covered in part or in full by my insurance carrier. In the event the insurance does not pay the dentist for covered, non-covered, or services applied to a deductible, I am fully responsible for the balance.

AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay directly to Minster Dental Care otherwise payable to me. I understand that my insurance carrier may pay less then a the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or dependents.

Signature of Patient (over 18) Or Parent / Guardian ______________________ Date ______________

Relationship to Patient: ______________________