BLUE DIAMOND FAMILY DENTAL, S.C.

1502 MAIN STREET • BLOOMER, WI 54724
(715) 568-2363

DATE ______________________ ACCOUNT NUMBER ______________________

PATIENT INFORMATION

Patient Name ______________________ Nick Name ____________ Phone ____________
Last First M.I.

Address ____
Street City State Zip

Sex M ______ F ______ Age ______ Birthdate ______________ Marital Status ______________

Employed by ______________________ Work Phone ____________ Cell Phone ____________

Text Reminder Yes______ No______ Email ______________________

Social Security # ______________________ Spouse's Social Security # ______________________

Spouse's Name ______________________ Spouse's Birthdate ______________________

Spouse Employed by ______________________ Work Phone ______________________

Who is responsible for this account? ______________________ Relationship to Patient ______________________

Have you or other family members been in our office? Yes No If yes, name ______________________

PRIMARY DENTAL INSURANCE

Name of insurance company ______________________ Group Number ______________________

Identification Number ______________________ Subscriber Date of Birth ______________________

Subscriber ______________________ Employer ______________________
Last First M.I.

Social Security # ______________________

SECONDARY DENTAL INSURANCE

Name of insurance company ______________________ Group Number ______________________

Identification Number ______________________ Subscriber Date of Birth ______________________

Subscriber ______________________ Employer ______________________
Last First M.I.

Social Security # ______________________

EMERGENCY CONTACTS

Nearest relative or friend not living with you whom we can contact in an emergency.

Name ______________________ Relationship ______________________ Phone ____________

FINANCIAL AND INSURANCE ARRANGMENTS

Payment is expected at the time of service, at which time you will receive 5% discount for payments made in full. Visa and Master-card is available. Financial agreements can be made with payment plans.

As an added service to you, your insurance claim will be processed by our office. I understand that I am responsible for all charges not covered by my dental insurance. I authorize the release of any information to the insurance carrier. I also authorize the insurance payment direct to Blue Diamond Family Dental, S.C. from my insurance carrier for their performed services.

I hereby authorize and consent to the performance of dental treatment which the dentist and I agree is necessary. A $5.00 monthly rebilling charge will be added to all outstanding balances over 90 days old.

Patient or subscriber, parent ______________________ Date ______________________