Patient Information Form

Name: _____
(First) (Last) (Middle Initial)
Birth Date: _____ (M/D/Y) **S.I.N.** (optional) _____
Phone: (Home) _____ (Work) _____ (Cell) _____
Address: _____
City: _____ **Postal Code:** _____
E-mail: _____
Please make sure your contact & email information is always up to date for reminders
WE USE AN AUTOMATED SYSTEM FOR REMINDERS
How did you hear about us? _____
Whom can we thank for the referral? _____
Emergency Contact: (Name) _____ (Phone) _____
Parent/Guardian Name: (If patient is under 18) _____

Insurance Information

Please provide your insurance card to our receptionist to photo copy for your chart
Subscribers Name: _____ **Birth Date** (M/D/Y) _____
Employer Name: _____
Insurance Company: _____
Policy Number: _____
Personal Identification Number: _____

SECONDARY INSURANCE ***if applicable***
Subscribers Name: _____ **Birth Date** (M/D/Y) _____
Employer Name: _____
Insurance Company: _____
Policy Number: _____
Personal Identification Number: _____

Please let us know immediately if your coverage has changed so we can keep our files updated.

Important Payment Information:

- **WE REQUIRE 2 BUSINESS DAY'S NOTICE TO RESCHEDULE A BOOKED APPOINTMENT TO AVOID A $100 CHARGE**. You are responsible for your appointment regardless of receipt or non-receipt of reminders.
- Contact your insurance carrier to determine your dental coverage
- We do not accept personal cheques.
- **You are responsible for payment of any treatment your insurance does not cover**.
- We will accept assignment from your insurance company as long as they will pay the dentist directly and we have a current Credit Card number from you to keep on file. In the event your insurance does not break down your payment we will wait for the payment and process the remaining balance on your Visa or MasterCard. If you do not wish to leave your Credit Card on file you can pay first and have your insurance reimburse you directly.
- Interest will be charged on all overdue accounts.

Credit Card # _____ Exp. _____

I authorize Core Dental to charge my credit card for any unpaid balance that my insurance does not cover.

I authorize release to Core Dental the information contained in claims submitted electronically. I hereby assign my benefits, payable from claims submitted electronically to Core Dental and authorize payment directly to them. This authorization shall continue in effect until the undersigned revokes the same.

Signature_____ **Date**_____