PATIENT APPLICATION

please fill out and sign

Today's Date _____

PATIENT INFORMATION

Name _____
Last First Mi

How do you wish to be addressed? _____

Email _____

Home Address _____

Birthday _____

_____
City State Zip

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Widowed

Sex
☐ Male
☐ Female

Phone: Home _____

Cell _____

____ I consent to Willow Dental Group using my cell phone number to call or text regarding appointments and treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

Are any family members patients with us? _____

Who (please list all)? _____

Business _____

Whom may we thank for referring you? _____

Social Security # _____

Employer/Occupation _____

INSURANCE & BILLING INFORMATION

We provide the courtesy of filling out your insurance claims on your behalf on the date your service is rendered. Please provide us with your Insurance ID card at time of registration to assist you in receivingyour benefits. You are responsible for all fees at the time of service.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.

Primary Dental Insurance _____ Insurance ID# _____

Subscriber/Insured Name _____ DOB _____ SSN# _____

Employer _____ Group# _____ Relationship to Patient _____

Secondary Dental Insurance _____ Insurance ID# _____

Subscriber/Insured Name _____ DOB _____ SSN# _____

Employer _____ Group# _____ Relationship to Patient _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

_____

Date of Last Dental Care _____

PLEASE READ AND INITIAL THE FOLLOWING

____ I authorize the dentist(s) to perform diagnostic procedures (i.e., radiographs, study models, photography, or other diagnostic aids) and treatment as may be necessary for proper diagnosis, planning and dental care.

____ I understand and consent to having the photographs, radiographs, study models and other diagnostic aids that are part of my clinical record to be utilized for illustrative and educational purposes in research, lectures and publications my dentist deems proper.

____ I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Willow Dental Group.

____ I understand that appointments broken with less than 24 hour notice will be charged a minimum fee of $75, $105 for a specialist, or up to full appointment fee.

____ I authorize the release of any information concerning my healthcare, advice and treatment to another dentist, physician, or healthcare professional and/or insurance company to secure payment of benefits.

____ I understand that all professional services are charged directly to the patient and I am responsible for payment of fees, including all collection/attorney fees.

_____

Responsible Party Signature Date

6753 N. Willow Ave.
Phone: 559.434.1088 • Fax: 559.314.6753
www.willowdentalgroup.com