Welcome to Crystal Valley Family Dentistry P.C.

We are pleased to welcome you to our practice. Please take a few minutes and fill out this form as completely as you can. If you have any questions we will be glad to assist you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ SS # _____
Address _____ Zip _____
Age ____ Birthdate _____ Home Phone (_____) _____ Bus. Phone (_____) _____
Email _____ Cell Phone (_____) _____
Whom may we thank for referring you? _____
Employer _____ Occupation _____
Employer's Address _____ Zip _____

Person Responsible for Account

Name _____ SS # _____
Address _____ Zip _____
Age ____ Birthdate _____ Home Phone (_____) _____ Bus. Phone (_____) _____
Email _____ Cell Phone (_____) _____
Marital Status: Single____ Married____ Widowed____ Separated____ Divorced____
Employer _____ Occupation _____
Employer's Address _____ Zip _____

Primary Insurance

Person Responsible for Account: Last Name _____ First Name _____ Initial _____
Driver's Lic. # _____ State _____ Birthdate _____ SS # _____
Relationship to Patient _____
Address (If different from patient) _____ Zip _____
Person Responsible Employed by: _____ Occupation _____
Business Address _____ Bus. Phone (_____) _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Other dependents covered under this plan _____

Secondary Insurance

Person Responsible for Account: Last Name _____ First Name _____ Initial _____
Driver's Lic. # _____ State _____ Birthdate _____ SS # _____
Relationship to Patient _____
Address (If different from patient) _____ Zip _____
Person Responsible Employed by: _____ Occupation _____
Business Address _____ Bus. Phone (_____) _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Other dependents covered under this plan _____

Authorization

I authorize my insurance company to pay Crystal Valley Family Dentistry P.C. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that payment is due in full at time of treatment unless prior arrangements have been approved. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that a 1.5% monthly late fee may be charged if payments are not received within 30 days of the billing date. If after 90 days no payment has been received, I understand that a collections service may be used and agree to pay all collections cost, including, but not limited to responsible attorney's fees.

Signature _____ Date _____