Welcome

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

Patient Information

Date _____ Home Phone (____) _____ Cell Phone (____) _____

Name _____ SS/HIC/Patient ID # _____
    Last Name   First Name   Middle Initial

Address _____ E-mail _____

City _____

State _____ Zip _____

Sex ☐ M   ☐ F   Age_____ Birthdate _____

☐ Married   ☐ Widowed   ☐ Single   ☐ Minor
☐ Separated   ☐ Divorced   ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
    Last Name   First Name   Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____
_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
                                             Name of Insurance Company(ies)

Michael J. Fernandez, D.M.D., P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X _____   _____
  Signature of Patient, Parent, Guardian or Personal Representative   Date

_____   _____
  Please print name of Patient, Parent, Guardian or Personal Representative   Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.