Shelton Dental Excellence

Personal Information

Name _____ SOC.SEC. # _____
Last First Initial

Address_____ Home Phone_____ Cell_____

City _____ State_____ Zip _____ Email _____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Single ☐ Married ☐ Other_____

Whom may we thank for referring you? _____

In care of emergency, who should be notified? _____ Phone _____

Person responsible for account _____
Last First Initial

Relationship _____ Birth date _____ SOC. SEC. # _____

Address (if different then patient's) _____ Phone _____

City _____ State _____ Zip _____

Responsible party employed by _____ Occupation _____

Business address _____ Phone _____ Cell _____

Primary Insurance

Insurance company _____

Subscriber ID # _____ Group # _____

Additional Insurance

Is the patient covered by additional insurance? ☐ YES ☐ NO

Subscriber name _____ Relationship to patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber employed by _____ Business phone _____

Insurance company _____

Subscriber ID # _____ Group # _____

Method of payment

Which of the following methods of payment will you be using? I understand I am responsible for all costs relating to my treatment.

Method of payment: ☐ Cash ☐ Check ☐ VISA ☐ MC ☐ Discover ☐ Care credit

All information written is true and complete. Signature: _____ DATE: _____

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company as we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. INITIALS: _____

HIPPA Acknowledge of Receipt of Notice of Privacy Practices

Share information with: Name: _____ Relationship: _____

Print Name: _____ Signature: _____ Date: _____

**YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT ☐ Patient Refused to Sign HIPPA