HINNANT
FAMILY DENTISTRY

Insurance & Billing Information

Patient Last Name: _____ First: _____ Middle Initial: ___ Preferred: _____

Sex: _____ Marital Status (Please Circle): Single Married Divorced Widowed Separated

Date of Birth: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____

Social Security #: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Spouse's Employer: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____
(other than spouse)

Primary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of Birth: _____ SS #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of Birth: _____ SS #: _____

Authorization and Release

I have been given a copy and have had the opportunity to read this office's Notice of Privacy Practices. I understand that by signing this form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operation. If insurance is involved in treatment, I authorize and request my insurance company to pay directly to the dentist. I understand insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

x_____ _____
Signature of patient (or parent/guardian if minor) Date

I understand that where appropriate, a credit report may be obtained.

x_____ _____
Signature of patient (or parent/guardian if minor) Date