Welcome to Albertville Family Dental

Patient Information

Maiden _____

(please circle one)

Patient Name: Dr. Mr. Mrs. Ms. Miss (First) _____ (M.I.) ____ (Last) _____

Date of Birth: _____ Social Security No. _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Occupation: _____

Employer: _____ Work Phone: _____

Spouse's Name: (First) _____ (M.I.) _____ (Last) _____

Spouse's Employer: _____ Occupation: _____

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Child ☐ Guardian ☐ _____

Other members in the family (please list names and ages): _____

_____

Email Address? _____

Whom may we thank for referring you? _____

Responsible Party Information

☐ Same as Above

Name: (First) _____ (M.I.) _____ (Last) _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Date of Birth: _____

Work Phone: _____ Social Security No. _____

Employer: _____

Insurance Information

☐ No Dental Insurance

Policyholder Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian Social Security No. _____

Employer: _____

Insurance Company: _____ Group No. _____

Insurance Co. Address: _____

Do you have dual insurance coverage? ☐ No ☐ Yes (If yes, please complete the following)

Policyholder Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian Social Security No. _____

Employer: _____

Insurance Company: _____ Group No. _____

Insurance Co. Address: _____

Emergency Contact Name: _____ Phone: _____

I certify the above information is true and correct, and I agree to full financial responsibility of all charges for treatment rendered, regardless of insurance involvement.

If you have insurance - Insurance is designed to reimburse the policyholder for loss, and is a contract between the policyholder and the insurance company. As a courtesy to you, we will submit your insurance claim on your behalf and will do all we can to help you collect legitimate claims. In the event your company is slow to pay or disallows the claim payment, the amount owed is your responsibility. There will be a finance charge of 1.5% per month (or 18% per year) for balances over 30 days. There will a 2% MN CARE TAX charge added to all services.

Signature (parent's signature if a minor) _____ Date: _____