OMEGA DENTAL

14551 W. Indian School Rd. #200
Goodyear, AZ 85395

We are complimented that you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? ______________________

Patient Information

Date __________ Patient's Name ____
Last First Middle

Address ____
Street City State Zip

Cell Phone (____) ______________ Home Phone (____) ______________ Social Security # ______ - ____ - ______

Birthdate _____/_____/_____ If patient is a minor, give parent's/guardian's name ______________________

If patient is a full-time student, fill in school name ______________________________________

Emergency Contact ______________________________________ Phone (____) ______________

Responsible Party Information

Name ____
Last First Middle Marital Status

Residence ____
Street City State Zip

Mailing Address ____
Street City State Zip

Home Phone (____) ______________ Work Phone (____) ______________ Social Security # ______ - ____ - ______

Birthdate _____/_____/_____ Relationship to patient ______________________

Employer ______________________________ Occupation ______________________

Employer's Address ____

Insurance Company ______________________________ Group # ______________________

Insurance Company Address ____

Phone (____) ______________

Secondary Insurance Information

If you have dual coverage, please fill out the following:

Spouse's Name ______________________________________ Work Phone (____) ______________

Social Security # ______ - ____ - ______ Birthdate _____/_____/_____ Relationship to patient ______________

Employer ______________________________ Occupation ______________________

Employer's Address ____

Insurance Company ______________________________ Group # ______________________

Insurance Company Address ______________________________________ Phone (____) ______________

Payment Responsibility

For our patients without dental insurance . . . I understand that all responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

For our patients with dental insurance . . . I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately repsonsible for payment of all dental services provided in this office for myself or my dependents. My co-payment is due and payable at the time services are rendered. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office.

If it becomes necessary to enlist a collection agency, the responsible party agrees to pay all costs of collection.

I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

____ Date ______________

Parent or Responsible Party ______________________________ Relationship to Patient ______________