Weber Dental

Family Dental Care

Because You Deserve a Healthy Smile

Welcome to Weber Dental!
We are happy to be part of your dental care.

Whom may we thank for referring you to us? _____ ***(name/internet/signage/other)***

PATIENT INFORMATION

Patient's full name: _____ Preferred to be called: _____

Date of birth: _____ SS#_____ Sex: ___M ___F

Mailing Address: _____

Primary Phone: _____ Home/Work/Mobile

Alternate Phone: _____ Home/Work/ Mobile

Email: _____

Employer: _____

Spouse Information

Spouse's Name: _____ Date of birth: _____

Spouse's Phone Number: _____ Employer: _____

Insurance Information

Primary:

Policy holder: _____

Member ID#: _____

Group Name and Number: _____

Insurance Name and Address: _____

_____

Phone Number: _____

Secondary:

Policy holder: _____

Member ID#: _____

Group name and number: _____

Insurance Name and Address: _____

_____

Phone Number: _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis, and/or treatment. This release is solely for facilitating the billing and reimbursement directly to Weber Dental of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered and understand that complete payment will be made at each treatment unless other financial arrangements have been previously arranged. I understand that my dental insurance is a contract between me and the insurance company and NOT between Weber Dental and your insurance company. I fully understand that it is my financial responsibility for all dental treatment regardless of insurance.

Patient Signature: _____**Date:** _____

****Emergency Contact Name:** _____**Phone:** _____******