PATIENT INFORMATION

A. GENERAL INFORMATION:

NAME_____
(Last) (First) (Middle) (Preferred Name)

HOME ADDRESS_____
(Street)

_____
(City) (State) (Zip)

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)

_____
(Street)

_____
(City) (State) (Zip)

SOCIAL SECURITY NUMBER_____MARITAL STATUS M S W D

HOME PHONE_____DATE OF BIRTH_____

WORK PHONE _____MOBILE PHONE_____

REFERRING DENTIST_____

SPOUSE'S NAME OR EMERGENCY CONTACT _____

ADDRESS _____
(Street)

_____PHONE NUMBER_____
(City) (State) (Zip)

EMAIL ADDRESS_____

B. EMPLOYMENT INFORMATION:

EMPLOYED BY_____OCCUPATION_____

ADDRESS_____
(Street) (City) (Zip) (Phone)

C. INSURANCE INFORMATION FOR PROCESSING CLAIMS:

IF YOU HAVE DENTAL INSURANCE, COMPLETE THE FOLLOWING. PLEASE GIVE PRIMARY INSURANCE ONLY. WE DO NOT FILE SECONDARY INSURANCE.

POLICY HOLDER'S NAME _____RELATIONSHIP TO PATIENT_____

POLICY HOLDER'S EMPLOYER_____BIRTHDATE_____

INSURANCE COMPANY_____GROUP PLAN #_____

ADDRESS: _____
(Street) (Phone Number)

_____
(City) (State) (Zip)

INSURANCE IDENTIFICATION NUMBER_____

I understand that Dr. Phyllis Cook and/or associates do not accept Medicare & will not file Medicare claims.

_____
Signature of Patient/or Responsible Party

I understand that I am responsible for any fees for professional services that are rendered. I certify that I have read and understand the above. I will not hold my dentist, or any other member of her staff, responsible for any errors or omissions that I may have made in the completion of this form. I understand that all accounts over 90 days past due will accrue interest of 1.5% per month (18% APR) on the unpaid balance until paid in full.

Signature of Patient/or Responsible Party **Date**

(OVER)

If you would like for us to assist you in processing your insurance forms, we need to have your signature on file. This gives us the authorization to release treatment information to your insurance carrier and authorizes them to pay benefits directly to us to be applied against your account.

By having your signature on file, we can use our own computer-generated forms, which may not be available for you to sign when your treatment is provided.

By your signature, you also understand that this office does not participate with any insurance company. We are happy to file your claims and accept insurance payment. However, any amount your insurance company considers over and above their usual allowance and your coinsurance is your responsibility.

AUTHORIZATION TO PAY BENEFITS TO DENTIST: I hereby authorize payment directly to Phyllis B. Cook, DDS, MPH, PA of the Group Insurance Benefits otherwise payable to me.

_____ _____
(Signature) (Date)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Phyllis B. Cook, DDS, MPH, PA to release any information relating to my dental claims.

_____ _____
(Signature) (Date)

I understand that I, _____, am responsible for my coinsurance and any amount above what my insurance company considers their usual and customary allowance.

_____ _____
(Signature) (Date)

Your insurance company reserves the right to conduct reviews for possible errors in reimbursement, and may request a refund for insurance payment issued in error.

I understand that in the event of an **insurance** request for re-payment to the insurance company that I, _____ am responsible for repayment.

_____ _____
(Signature) (Date)