

# Welcome to Tavares Dental Excellence

*"Come in as a Patient, Leave as a Friend."*

## PATIENT INFORMATION

Date \_\_\_\_\_ Birth date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home number (\_\_\_\_) \_\_\_\_\_

Cell number (\_\_\_\_) \_\_\_\_\_

Work number (\_\_\_\_) \_\_\_\_\_

Best time and number to reach you? \_\_\_\_\_

Married  Widowed  Single  Minor

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## PERMISSION TO RELEASE INFORMATION TO NON-DENTAL PERSONS

Please list any family members (including spouse), friends or home health care personnel you authorize to receive information on your dental condition (e.g. appointments, proposed, pending, completed treatment) or billing and/or insurance information.

I, \_\_\_\_\_ give Tavares Dental Excellence (Doctor and staff) permission to release dental/billing information to the following people:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## FINANCIAL & DENTAL INSURANCE INFORMATION

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will in place until otherwise notified in writing.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## CONSENT AGREEMENT

I understand that I am financially responsible for all charges incurred. As a condition of treatment by this office, financial arrangements must be made in advance of treatment.

The undersigned hereby authorizes the Doctor/staff members to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor/staff members to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my or my dependent's case, with my consent. I also understand the use of anesthetic agents embodies a certain risk. I further authorize and consent that Dr. \_\_\_\_\_ may choose and employ such assistance as he deems fit.

I hereby give the absolute right and permission to use my audio/video materials, including photographs/slides/video for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said materials. I give my permission to videotape procedures for educational purposes.

I grant permission to Tavares Dental Excellence to contact me via my email address \_\_\_\_\_. Correspondence may include confirmations, newsletters, special announcements and offers. Privacy is important to us. We will not sell, rent, or give your name or address to anyone. At any point, you can unsubscribe from email by clicking on the unsubscribe link at the bottom of every email.

\_\_\_\_\_  
Patient Signature (Parent/Guardian if minor)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date