OUR EMERGENCY PHONE # IS (203) 671-2019 • VISIT OUR WEBSITE: WWW.DENTALGROUPCT.COM

Complete and return the questionnaire to the receptionist. **All information will be considered confidential.**

GENERAL INFORMATION

PHYSICIAN'S NAME OR HEALTHCARE FACITLITY _____

PATIENT NAME _____ **EMAIL** _____ FACEBOOK _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ **CELL** _____ DATE OF BIRTH _____ SOCIAL SEC.# _____

EMPLOYER _____ DRIVER'S LIC.# _____

ADDRESS _____ TELEPHONE _____ LICENSE PLATE# _____

PARENT OR SPOUSE'S NAME _____ WHOM MAY WE CONTACT IN AN EMERGENCY? _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ DATE OF BIRTH _____ SOCIAL SEC.# _____

EMPLOYER _____ CITY _____ _____ TELEPHONE _____

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? _____

DO YOU HAVE A SECONDARY INSURANCE? _____

IF YES, NAME OF INSURANCE CARRIER _____

POLICY # & SOC. SEC. # OF CARRIER _____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT? _____

CREDIT INFORMATION

DO YOU HAVE VISA/MASTERCARD? Yes - No IS IT: CREDIT or DEBIT

OFFICE POLICY

***Patients with Insurance:** Copayment for service is due at the time of service. I authorize my insurance to send payment directly to the Dental Group of Meriden-Wallingford.*

***Patients without Insurance:** Payment IN FULL as services rendered.*

You are encouraged to read your insurance policy to determine the annual maximum allowed; and the percentage paid by your carrier.

Patient responsible for amounts not covered by Insurance.

There will be a charge for each broken appointment.

I give permission to the Dental Group of Meriden-Wallingford to perform dental treatment with my full knowledge. I consent to an exam & dental x-rays. I WILL BE RESPONSIBLE FOR ALL CHARGES AND AGREE TO MAKE PROMPT PAYMENT FOR TREATMENT. In the event of default your account will be subject to finance charge. **You and/or your guardian are liable for all collection costs and attorney fees. I consent to the release of information contained in my dental records.**

I have had full opportunity to read and consider the contents of the HIPPA Consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE _____ Date: _____

Personal Representative's Name: _____

If this Consent is signed by a personal representative on behalf of the patient.

Relationship to Patient: _____