

Loudoun Dental Smiles

Welcome To Our Office

Today's Date _____

Patient's Name _____ Phone _____ Cell _____

Name you prefer to be called _____ E-Mail Address _____

Home Address _____ City _____ Zip _____

Occupation _____ Employed by _____

Business Address _____ Phone _____

Date of Birth _____ Male Female Single Married Other

SS No. _____ **Whom can we thank for referring you?** _____

Spouse or Parent (if minor) _____

Emergency contact name and phone _____

Responsible Party/Insurance

(if patient is spouse or minor)

Insurance Subscriber Name _____ Phone _____

SS No. _____ Date of Birth _____

Dental Insurance Carrier _____ Phone _____

Subscriber No. _____ Group No. _____ Group Plan _____

NOTES: _____

Please understand that as a dental care provider, our relationship is with you and not with your insurance company. Filing of insurance claims is a courtesy that we extend to our patients but all charges are your responsibility from the date services are rendered. We have no leverage on assuring that your claims are paid. Our office is not responsible for collecting your insurance claim or for negotiating disputed claims. We invite you to bring your policy booklet with you and we will be happy to assist you in understanding your coverage.

Signature of Patient or Responsible Party _____ Date _____
(parent or guardian if patient is a minor)