WELCOME TO BLUE HOUSE DENTISTRY

1. Patient's Name (first) _____ (middle initial) _____ (last) _____
Driver License _____ Social Security # _____ E-mail _____
Address _____ Apt _____
City _____State _____ Zip _____
Telephone (Home) _____ (Cell) _____ Birth Date ___/___/___ Age ___ Sex___

Employer _____ Telephone # _____
Address _____ City _____ State _____ Zip _____

3. Responsible Party _____ **Driver** License _____
Relation to Patient _____ Social Security # _____
Employer _____ Telephone # _____

4. In Case of Emergency Call_____Relationship_____
Telephone (Home) _____ (Work) _____ (Cell) _____
Address_____ City_____ State _____Zip_____

5. Whom can we thank for referring you to our office? _____

6. Insured Patients Only
Insured is Self Spouse Mother Father other _____
Insurance Co. _____ Telephone # _____
Insured's Name _____ ID _____ Birth Date __/__/____ Group # _____

YES NO Are you covered by a second insurance company?
If yes, Insurance Co. _____ Telephone # _____
Insured's Name _____ ID _____ Birth Date __/__/____ Group # _____
Our office is happy to cooperate with patients covered by dental insurance. As a courtesy, we will fill out and file all necessary forms; however, you will be asked to pay the deductible and your portion of the charges the day of service. We will gladly estimate your coverage, and we need your patient portion while waiting for payment from your insurance company. Remember, it is just an **ESTIMATE**. If, after 45 days, the insurance company has not paid, the balance will be due in full.
I agree if any default of the above agreement on my part needs legal action, I shall assume all responsibility for interest, and reasonable attorney fees. I have read and understand the above information.
Print Name_____ Signature _____ Date____/____/____

Assignment of Benefits
I hereby authorize _____Insurance Company to make payment directly
Ned Paniagua DMD for the dental benefits otherwise payable to me. The foregoing agreement is made in consideration of professional services beginning on _____.I hereby represent that I am of legal age and legally competent to make this assignment.
Print Name_____ Signature _____ Date____/____/____

7. Non-Insured Patients
Payment for patients without dental insurance is due in full at the time of service, unless specific arrangements are made in advance.

As a convenience we accept cash, check, credit cards and we offer Care Credit.