PATIENT INFORMATION

Patient Name: _____
LAST FIRST MI

SS#: _____-_____-_____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ _____ _____
HOME WORK CELL

Email Address: _____

Marital Status: _____ Sex: M or F

Emergency Contact:_____
LAST FIRST CONTACT NUMBER

RESPONSIBLE PARTY(if other than patient)

Name:_____
LAST FIRST MI

SS#: _____-_____-_____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ _____ _____
HOME CELL WORK

Marital Status: _____ Sex: M or F

DENTAL INSURANCE INFORMATION

Do you anticipate that your DENTAL INSURANCE will assist you with your account? ☐ Yes ☐ No

Insured's Name: _____ Insured's Date of Birth _____

Insurance Company _____ Insured's Social Security No. _____-_____-_____

Ins. Co. Address_____City_____State_____Zipcode_____

Insured's Employer _____ Group No._____ Policy No._____

Do you have double Insurance coverage? ☐ Yes ☐ No

FINANCIAL POLICY

Full payment is expected at the time of each visit. For extensive cases, financial arrangements made in advance are available. Dental insurance is an agreement between you and the insurance company. Insurance only assists and does not relieve one of any financial obligations. We will never allow the limitations of your benefits to compromise the quality of your care. Many of our patients participate in CareCredit, Lending Club, and/or iCare, which are all special dental financing programs. ☐ Yes, please give me more information about these payment options.

CONSENT: The undersigned hereby authorizes Andrew G. Gambrell, D.M.D. and associates to take radiographs, study models, photographs, or any other diagnostic aids deemed necessary by Andrew G. Gambrell, D.M.D. to make a thorough diagnosis of the patient's dental needs. I also authorize Andrew G. Gambrell, D.M.D. to perform any and all forms of treatment, medications, and therapy that may be indicated. All information on this page and the Medical History Form is correct and fully understood by me. I understand the financial policy and also assign all insurance benefits, if applicable, to Andrew G. Gambrell, D.M.D.

Dr. Gambrell occasionally uses photos of patients for promotional and teaching purposes. Please initial if you prefer your photos not to be used for dental education. _____Date_____

PATIENT Signature (Parent of Child) _____ Date _____