Smith Mountain Lake Dental Practice

Bryan G. Sicher, D.M.D., P.C.

PATIENT INFORMATION

Name____

Address____

____

Telephone Numbers: Home_________________________ Work_________________________

Cell_______________________________ Email ____

Patient SS#_________________________________ Birthdate__________________________________

Whom may we thank for referring you? ____

In case of an emergency, who should be notified? ____

Relationship_____________________________________Telephone________________________________

AUTHORIZATION / RECORD RELEASE: I authorize the release of medical/dental information, including diagnosis and records of any treatment and examination rendered to me or the above named patient, to third party payers and/or specialists regarding dental care upon my verbal consent.

Signature____Date____________________________

DENTAL INSURANCE

Name of Insured____

Birthdate_____________________________________ SS#____

Employer____________________________________ Relationship to Patient_________________________

Insurance Co.____ Group #_________________________

Do you have additional dental insurance? _____Yes _____No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance with ____and authorize payment of dental benefits otherwise payable to me directly to Dr. Bryan G. Sicher for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party____ Date____________________