Patient's Last Name _____First Name: _____ Date of birth_____

Street: _____

Town: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell _____

Email: _____

Person responsible for payments:

Name _____ Relationship:_____

Address: _____

INSURANCE:

Insured Employee_____ Employee's date of birth _____

Social Security Number _____ Relationship to patient _____

Membership Number _____ Group Number _____

Primary Insurance Company & Address: _____

_____

Employer Name & Address: _____

_____

Secondary Insurance Company & Address: _____

_____

Employer Name & Address: _____

_____

Please read, date and sign the statement below. This allows us to bill your insurance company.

Signature on File: I give the office of Heim & Carroll DMD LLC permission to enter my signature on dental insurance forms for services rendered in this office for all of the above insurance carriers.

I have been informed of the treatment plan and associated fees. I understand I am responsible for all costs of dental treatment. To the extent permitted under applicable law, I authorize the release of any information relating to this claim.

I hereby authorize payment of dental benefits otherwise payable to me directly to Heim & Carroll DMD LLC.

Signature:_____ Date_____