HEIM AND CARROLL DMD LLC

PATIENT INFORMATION

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:

Primary 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 Insured Employee_____ Employee's date of birth _____

Social Security Number _____ Relationship to patient _____

Membership Number _____ Group Number _____

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_____