NEW PATIENT ACQUAINTANCE FORM

Patient's Name:____________________________________ Male/Female DOB:_____________________

Please circle: child single married divorced widowed

If a child: Parent's Name:_____________________________________ DOB:_____________________

Name of Spouse:_____________________________________________ DOB:_____________________

Street Address:_____________________________________________________________________________

City:____________________________________ State:______________________ Zip:_________________

Cell Phone:________________ Home Phone:____________________ Work Phone:_________________

Email Address:______________________________________________

Patient Employed by: (if student – name of school):_____________________________________________

Business Address:____________________________________________________________________

City:____________________________________ State:______________________ Zip:_________________

Spouse/Parent Employed by: (if student – name of school):_______________________________________

Business Address:____________________________________________________________________

City:____________________________________ State:______________________ Zip:_________________

Patient Social Security #:_______________________ Driver's License #:____________________________

Person Responsible for Account:_______________________________________________________________

Responsible Party's Social Security #:_______________________ Driver's License #:_________________

Whom may we thank for referring you?_______________________________________________________

4255 Bryant Irvin Road, Suite 111, Fort Worth, TX 76109
Tel: 817-731-9487 • Fax: 817-731-2846
www.countrydaydental.com

# DENTAL INSURANCE

Country Day Dental is happy to assist you in receiving your maximum dental insurance benefits.
Please be aware that while Country Day Dental does accept insurance, we are **not** in-network with any insurance carriers. As a courtesy we will file all insurance claims for you. We will provide estimates, but these are not a guarantee of insurance payments. Dental insurance is a contract between your employer, who selects your coverage limits, and the insurance company. You (the subscriber) will receive the dental benefits as defined by this plan. Insurance payments received by this office will be credited to your account or refunded to you in the case of an overpayment. You are responsible for all dental fees (charges) that your insurance company has not paid, for whatever reason, within a 60-day period from when treatment is begun. If requested, we will submit a pre-determination letter to your insurance company. These usually take up to 6 weeks to be processed.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND TO ABOVE INFORMATION:

Patient or Responsible Party Signature:________________________________________

PATIENTS WITH INSURANCE MUST COMPLETE AND SIGN THIS PORTION

Name of Policy Holder________________________________________________

Name of Insurance Company____________________________________________

Policy or Group Number_______________________ Phone Number____________________

RECORDS RELEASE: I hereby authorize Country Day Dental to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care.

Patient or Responsible Party Signature:________________________________________

ASSIGNEMTN OF BENEFIT: I also authorize and request your company to PAY DIRECTLY TO THE ABOVE NAMED the amount due to me in my pending claim for dental treatment or services, by reason of such treatment or services rendered to me.

Patient or Responsible Party Signature:________________________________________

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