

WELCOME FORM

1. Patient's Name (first) _____ (middle initial) _____ (last) _____
Driver License _____ Social Security # _____ E-mail _____
Address _____ Apt _____
City _____ State _____ Zip _____
Telephone (Home) _____ (Cell) _____ Birth Date ____/____/____ Age ____ Sex ____
Single Married Widower Divorced
Employer _____ Telephone # _____
Address _____ City _____ State _____ Zip _____

2. Spouse _____ Driver License _____
Social Security # _____ Birth Date ____/____/____ Telephone # _____
Employer _____ Telephone (Work) _____

3. Responsible Party _____ **Driver License** _____
Relation to Patient _____ Social Security # _____
Employer _____ Telephone # _____

4. In Case of Emergency
Call _____ Relationship _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Address _____ City _____ State _____ Zip _____

5. Whom can we thank for referring you to our office? _____

6. Insured Patients Only
Insured is Self Spouse Mother Father other _____
Insurance Co. _____ Telephone # _____
Insured's Name _____ ID _____ Birth Date ____/____/____ Group # _____
YES NO Are you covered by a second insurance company?
If yes, Insurance Co. _____ Telephone # _____
Insured's Name _____ ID _____ Birth Date ____/____/____ Group # _____

Our office is happy to cooperate with patients covered by dental insurance. As a courtesy, we will fill out and file all necessary forms; however, you will be asked to pay the deductible and your portion of the charges the day of service. We will gladly estimate your coverage, and we need your patient portion while waiting for payment from your insurance company. Remember, it is just an **ESTIMATE**. If, after 45 days, the insurance company has not paid, the balance will be due in full.

I agree if any default of the above agreement on my part needs legal action, I shall assume all responsibility for interest, and reasonable attorney fees. I have read and understand the above information.

Print Name _____ Signature _____ Date ____/____/____

Assignment of Benefits

I hereby authorize _____ Insurance Company to make payment directly to **LUIS PANIAGUA DDS** for the dental benefits otherwise payable to me. The foregoing agreement is made in consideration of professional services beginning on _____. I hereby represent that I am of legal age and legally competent to make this assignment.

Print Name _____ Signature _____ Date ____/____/____

7. Non-Insured Patients

Payment for patients without dental insurance is due in full at the time of service, unless specific arrangements are made in advance.

As a convenience we accept cash, check, credit cards and we offer Care Credit.

*Thank you,
Aesthetic Dental Associates*