POLARIS
FAMILY DENTAL

Welcome! Thank you for selecting our dental team to provide you with the best possible dental care!

PATIENT INFORMATION

Name		Date of Birth	Social Security Number
Home Phone	Cell Phone	Work Phone	Email Address
Check appropriate boxes: ❑ Male ❑ Female	❑ Married ❑ Single	❑ Child ❑ Widowed	❑ Divorced ❑ Other
Address		City	State / Zip
Emergency Contact		Phone Number	Alternative Phone Number
Whom may we thank for referring you?			

RESPONSIBLE PARTY INFORMATION

Name		Date of Birth	Social Security Number
Home Phone	Cell Phone	Work Phone	Email Address
Address		City	State / Zip
Employer	City / State	Insurance Policy Holder?	❑ Yes ❑ No

DENTAL INSURANCE

Name of Policy Holder		Relationship to Patient	SS#/Subscriber ID
Date of Birth	Employer/Group Name		Phone
Dental Insurance Carrier		Group Number	Phone
Dental Insurance Carrier Address		City	State / Zip

Is the patient covered by a SECONDARY DENTAL Plan? If YES, please complete the following:

Name of Policy Holder		Relationship to Patient	SS#/Subscriber ID
Date of Birth	Employer/Group Name		Phone
Dental Insurance Carrier		Group Number	Phone
Dental Insurance Carrier Address		City	State / Zip

Assignment, Authorization, Release, and Agreement to Pay

I certify that I, and/or my dependent(s) have dental insurance coverage with _____ and assign directly to Dr. Jacklyn Winner, Inc. (Polaris Family Dental), hereafter referred to as "the Office", all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

The Office may use my health care information, including the diagnosis and record of any treatment or examination, to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.

I understand that the office staff will communicate with my insurance company(ies) and gather basic eligibility and benefit information, but I, in no way expect them to know all the possible exceptions that may be attached to my particular policy. I further understand that all quotes regarding insurance payments for services will be ESTIMATES. I am ultimately responsible for knowing my policy and paying any outstanding balances. Any dispute over insurance payment is my responsibility to resolve with my insurance company. My dental insurance is a contract between the insurance carrier and myself. The office will file insurance claims as a courtesy to me. I will provide accurate and updated information to the office. ***I understand that I am financially responsible for all charges, whether or not paid by insurance.***

The office reserves the right to run a credit report on all patients, unless fees are paid in full prior to treatment. If you would like a copy of your credit report, please ask the front desk.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative — Date

Privacy Practices Acknowledgment

I, _____ have been offered a copy of this office's Notice of Privacy Practices.
(Print Name)

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative — Date