

Account # _____

PATIENT:

Last name _____ First name _____ M.I. _____

Birthdate _____ Age _____ Marital status _____ Sex _____

Street _____ City _____ State _____ Zip _____

Patient Email address _____ SS# _____

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____

Employer Address _____ Phone _____

Emergency Contact Person _____ Relationship _____ Phone _____

BILL TO: **SELF** **SPOUSE "** **PARENT "** (please mark relationship)

Last name _____ First name _____ M.I. _____

Birthdate _____ Marital Status _____ SS# _____

Address _____ City _____ State _____ Zip _____

Spouse / Parent Email Address _____

Telephone Home _____ Work _____

Employer _____

Daytime Appointment Confirmation

Please mark preferred confirmation methods:

Phone call to _____ Email to _____ Text to Cell # _____

How did you hear about our office? Internet Phone book Friend/Relative

Dental Associates of Manhattan is a contracting provider for:

Delta Dental, Blue Cross-Blue Shield of Kansas, Cigna, Met Life, SunLife Financial & United Concordia.

Any other insurance will be Out of Network

We accept cash, check, MasterCard, Visa, Discover, and Care Credit.

It is understood that all professional services must be paid for at the time service is rendered unless specific prior arrangements are made with this office. It is the goal and responsibility of this office to provide the best dental care we possibly can. In return it is your responsibility to pay in full for this care.

This office will gladly assist you in the filing of your insurance claim. We ask that you provide us with the most accurate insurance information. Even though an insurance claim may be filed, you are still solely responsible for the total amount of your account. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Will you be using any dental insurance? Yes No

I have read and understood the information on this form.

Signature _____ Date _____