THE DENTAL CENTER OF EAGAN

3348 Sherman Court #202 Eagan, MN 55121
(651) 788-7924

Patient Information: **Date:**_____

Patient Name:_ _____ Social Security #:_____

Home Address:_____ Birthdate:____/____/____

City:_____ State: _____ Zip:_____ Referred by:_____

Home Phone:( )_____Work/Cell Phone:( )_____ Emerg contact#_____

Email:_____ **Full-Time Student at:**_____

Insurance Information: (Please give receptionist cards so that she can take copies of them.)

Dental Carrier:_____Policy Holder:_____DOB: _____

Policy Number:_____Group Number: _____

2nd Dental Carrier:_____Policy Holder:_____DOB: _____

Policy Number:_____ Group Number:_____

Person Responsible For Account: (Only if different from above)

Name:_____ Relationship to Patient:_____

Address: (If different from above.)_____

City:_____ State:_____ Zip:_____

County:_____ Home Phone: ( )_____

Birthdate:____/____/____ Social Security Number:_____

EMPLOYMENT NAME: _____

Employment Address:_____

City:_____ State:_____ Zip:_____

Business Number: ( )_____

When we call your insurance company to check eligibility and benefits, the amount stated by your insurance company is only an **estimate** and not a guarantee of coverage. The amount that insurance is estimated not to cover is due at the time of service.

Authorization

All fees are the responsibility of the patient or person responsible irrespective of insurance claims or other benefits. There will be a finance charge of 1.5% per month. I hereby authorize payment directly to the provider of benefits for these services as described. I understand I am financially responsible for charges not covered by this authorization. I also authorize release of any information relating to this claim. I understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs necessary to collect the debt, including fees charged by a collection agency.

Patient or responsible party:_____