

# 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: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

2<sup>nd</sup> Dental Carrier: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

ID 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: \_\_\_\_\_