BLAIR FAMILY DENTAL, S.C.
DONALD S. BLAIR, DDS
SINCE 1983

WELCOME TO BLAIR FAMILY DENTAL, S.C.

Thank you for selecting our family dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

1. PERSONAL INFORMATION

Today's Date

Patient's Name Birthdate

Wishes to Be Called

SSN ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Street Address P.O. Box

City State/Prov. Zip/Postal Code

Employer Occupation

E-Mail Address Referred By

2. RESPONSIBLE PARTY (WHO IS RESPONSIBLE FOR THE ACCOUNT?)

Legal Name Wishes To Be Called

Relationship to Patient

Birthdate

SSN E-Mail

Street Address P.O. Box

City State/Prov. Zip/Postal Code

Employer Occupation

Home Phone ( ) -

Work Phone ( ) - Ext. #

Cell Phone ( ) -

3. TELEPHONE

Home Phone ( ) -

Work Phone ( ) - Ext. #

Cell Phone ( ) -

Where do you prefer to receive calls? ☐Home ☐ Work ☐ Cell

In the event of an emergency, who should we contact? Name

Relationship Work # ( ) - Home # ( ) - Cell # ( ) -

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4. DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insured	Name of Insured
Relationship to Patient	Relationship to Patient
Insured's Birthdate	Insured's Birthdate
Insured's SSN	**Insured's SSN**
Employer	Employer
Insurance Company	Insurance Company
Group #	Group #
Member ID #	Member ID #
Insurance Co. Address	Insurance Co. Address

5. AUTHORIZATION AND RELEASE

I authorize the office of Blair Family Dental, S.C. to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to Blair Family Dental, S.C. insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of Patient or Parent/Guardian If Minor **Date**

6. FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

☐ Cash
☐ Personal Check
☐ Credit Card ☐ Visa ☐ Master Card

☐ I wish to discuss the dental office's policy.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask – we are always happy to help.

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