NEW PATIENT INFORMATION FORM

LAST NAME _____ FIRST NAME _____ TITLE _____

CELL PHONE _____ PREFERRED NAME _____

HOME PHONE _____ WORK PHONE _____

HOME ADDRESS _____CITY, ST, ZIP_____

D.O.B. _____ MARITAL STATUS _____ SEX _____

REFERRING DOCTOR _____ REFERRING PATIENT _____

E-MAIL ADDRESS _____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS _____

_____

RELATION TO PATIENT _____ S.S. # _____ D.O.B. _____

EMPLOYER NAME _____

INSURANCE COMPANY NAME AND ADDRESS _____

_____

GROUP #

_____

ID#

_____

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. The insurance policy is an agreement between you and the insurance company; we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time.

I hereby authorize Barry Laurent, D.D.S., to apply for benefits on my behalf for covered services rendered by this office and request that payments are made directly to Barry Laurent, D.D.S. I certify that the information reported is correct and further authorize the release of records, including x-rays, necessary to secure payment from the carrier. A photocopy of this authorization is to be considered valid as original.

I also understand and agree that I am financially responsible for all charges for myself and/or my dependents, whether or not paid by my insurance. I agree that in the event my account should become past due, I will pay interest on the unpaid balance at the rate of 1.5% per month (18% annually); and if my account is turned over to a third party for collection, I will also be liable for any and all costs incidental thereto, including all court costs and attorney's fees in the amount of 1/3 of the principal balance.

SIGNATURE _____ DATE _____