Family Dental Montgomery INC.
General and Implant Dentistry
Jerry P. Gao, DDS & Eileen TL Gao, DDS

Patient Information

DATE:____/_____/_____

Patient's name: _____ **Birth date**___/____/___ **Age**_____ ❑ **M** ❑ **F**
Mailing address: _____ **City** _____**State** _____ **Zip** _____
Email:_____ ❑ **Home phone** _____❑ **Cell phone** _____
Please check Primary Phone Contact preferred
Emergency Contact Phone #:_____ **Relationship to Patient:**_____

Is Patient a minor child? Y N **Full Time Student** Y N **School:** _____
Patient's Employer: _____ **Patient SS #:** _____

Responsible Party:_____**Relationship to Patient:** ❑Self ❑Father ❑Mother ❑Other
Mailing address: _____**City** _____**State** _____ **Zip** ____
Responsible Party Employer:_____**Responsible Party Phone #**_____

**We appreciate referrals to our office! Whom may we thank for referring you to our office?*
❑ **Patient:**_____ ❑ **Website** ❑ **Internet Search** ❑ **Sign/DriveBy** ❑**Other**_____

INSURANCE INFORMATION

❑ I AM NOT COVERED BY DENTAL INSURANCE

Insured Name:_____**Relationship to Patient :**❑ **SELF** ❑ **SPOUSE** ❑ **PARENT** ❑ **OTHER**
DOB:__/____/___**Employer:**_____**Group#:**_____**Insured SS/ID number:** _____
Dental Insurance Carrier :_____ **Dental Insurance Phone #**_____

Is the Patient covered by Secondary's Insurance? ❑ **YES** ❑ **NO**
Insured Name:_____**Relationship to Patient :**❑ **SELF** ❑ **SPOUSE** ❑ **PARENT** ❑ **OTHER**
DOB:__/____/___**Employer:**_____**Group#:**_____**Insured SS/ID number:** _____
Dental Insurance Carrier :_____ **Dental Insurance Phone #**_____

I certify that the insurance information provided is accurate and that I, and/or my dependent(s) have dental insurance coverage listed above. I authorize the use of my signature on all insurance forms submitted to collect payment for dental services rendered on my behalf. I assign directly to the treating Dentist all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges incurred during treatment and that my Insurance Carrier has the final determination on payment for all dental procedures according to my specific policy. This office will submit all dental forms and any additional information needed to your Insurance Carrier on your behalf to obtain the dental benefits. However, if your Insurance Carrier does not remit payment to this office 45 days after submission of your dental claim, you will be responsible for any balance on your account.

_____ _____

Please print name **Relationship of person filling out this form** **Signature of Parent/Guardian completing this form** **Date**

PATIENT PRIVACY POLICIES

*I acknowledge the receipt of this office's NOTICE OF PRIVACY POLICIES and I understand that I can request a copy of this policy at any time. I understand that this office will use my personal health information for the treatment, payment and/or health care operations. As required by law, our office adheres to written policies and procedures to protect the privacy of information about the patient that we create, receive, or maintain. Your answers on this form are for our records only and will be kept confidential subject to applicable HIPPA and State & Federal laws.*_____ _____

Signature of Parent/Guardian completing form **Date**