SPECIAL CARE DENTISTRY
— OF OREGON —

Patient Information

Patient Name: _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____
Email: _____ ☐ Married ☐ Single ☐ Child
Gender: _____ Age: _____ Date of Birth: _____ Social Security #: _____
Employer: _____ Occupation: _____
Work Address: _____ Work Phone: _____
Emergency Contact: _____ Phone: _____
Who may we thank for referring you? _____

Parent / Guardian Information (if under the age of 18)

Name: _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____
Gender: _____ Age: _____ Date of Birth: _____ Social Security #: _____
Employer: _____ Occupation: _____
Work Address: _____ Work Phone: _____

Insurance Information

Primary Insured (Subscriber): _____ Relationship to Patient: _____
Date of Birth: _____ Subscriber ID#: _____
Subscriber Employer or Plan Sponsor: _____ Group #: _____
Insurance Company: _____ Phone #: _____

Additional Insurance

Primary Insured (Subscriber): _____ Relationship to Patient: _____
Date of Birth: _____ Subscriber ID#: _____
Subscriber Employer or Plan Sponsor: _____ Group #: _____
Insurance Company: _____ Phone #: _____

Authorization and Release

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor. I realize 1.5% (18% APR) will be charges on balances over 30 days.
- I attest to the accuracy of the information on this page.
- I realize a collection fee will be charged for any uncollected balance that is transferred to a collection agency.

PATIENT / PARENT or GUARDIAN SIGNATURE PRINTED NAME DATE