Welcome to Oregon Dental Care

Patient Information

Date_____ Home Phone_____

Name_____ Soc. Sec. # _____
Last Name First Name Initial

Address_____ City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for referring you? _____

In Case of emergency who should be notified?_____ Phone_____

Responsible Party

Person Responsible for Account_____
Last Name First Name Initial

Relation to Patient_____ Birthdate_____ Soc. Sec.# _____

Address (If different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Business Address_____ Business Phone_____

Primary Insurance

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (If different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Subscriber Employed by_____ Business Phone_____

Insurance Company_____ Soc. Sec. # _____

Address_____ Phone #_____ Group #_____

Additional Insurance

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (If different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Subscriber Employed by_____ Business Phone_____

Insurance Company_____ Soc. Sec. # _____

Address_____ Phone #_____ Group #_____

Acknowledgement of Privacy and Financial Practices

_____ I acknowledge receipt of the Notice of Privacy Practices and understand that Oregon Dental Care may be required to disclose health information about me or my family members in order to obtain payment for dental services provided.

_____ I authorize my insurance company(s) to pay Oregon Dental Care all insurance benefits otherwise payable to me or my spouse for dental services rendered to me or members of my family.

_____ I understand that I am financially responsible for all charges for dental services rendered to me or my family members, whether or not we receive payment of insurance benefits.

_____ I understand that payment is due at the time of treatment, unless alternative financial arrangements are made, and I authorize Oregon Dental Care to perform credit checks.

_____ I understand that I will be charged a cancellation fee if I do not keep my appointment unless notice is given by 4:00 pm on the prior business day.

Signature_____ Date_____