Welcome!

Date_____ Date of Birth _____ Age_____

Patient's Name_____ Parent's Name (If Child) _____

Nickname_____ ☐Male ☐Female Social Security # _____

Address – Street_____ City_____ Zip_____

Telephone – Home_____ Cell_____ E-Mail _____

Employer_____ Position_____ Work Phone_____

Spouse/Parent Name_____ Spouse/Parent Social Security #_____

Spouse or Parent Employer/Position_____

Whom may we thank for referring you to our practice? _____

In case of emergency, what is the name, phone number and relationship of whom to notify_____
_____

Primary Dental Insurance (Please have insurance card available.)

Employee Name_____ DOB_____ Relationship to Patient_____

Name of Insurance Co._____ Ins. Phone #_____ ID# or Social Security #_____

Claims Mailing Address_____ Group/Policy # _____

Secondary Dental Insurance (Please have insurance card available.)

Employee Name_____ DOB_____ Relationship to Patient_____

Name of Insurance Co._____ Ins. Phone #_____ ID# or Social Security #_____

Claims Mailing Address_____ Group/Policy # _____

Consent:

I consent to the treatment/procedures diagnosed by Dr. Scott A. Broadbent that are necessary for proper dental care. I also consent for Dr. Scott A. Broadbent and his staff to disclose my records (or my dependent's records) to obtain payment and for any other activities related to services provided by this office.

I authorize payment directly to Village Dental, Scott A. Broadbent D.D.S., P.S. of all insurance benefits that would otherwise be paid to me. I understand that insurance coverage is a contract between me and my insurance company and that Village Dental, Scott A. Broadbent D.D.S., P.S. is a third party to this contract. I agree that I am responsible for all charges that are billed to my insurance company on my behalf, regardless of benefits or payment by my insurance company.

The above consents remain in effect until I revoke in writing. I attest that all information on this page is accurate.

Patient's or Guardian's Signature_____ Date_____