Dental Professionals

Hoffman Estates Dental Professionals

Patient Information

Patient's Name:_____ Date of Birth: _____

Social Security #:_____ Sex: M___ F___ Marital Status: Single, Married

Home Address: _____

Home Phone: (_____)_____ Cell Phone : (_____)_____

E mail Address: _____

Employer's Name: _____

Work Address: _____

Work Phone: (_____)_____ ext._____

Spouse's Name: _____

Whom may we thank for referring you? _____

In case of emergency:

Contact Name:_____ Relationship:_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Dental Insurance

Primary Insurance Company: _____

Subscriber: _____ Relationship to Patient: _____

Subscriber's S.S.N.: _____ Group #: _____

Subscriber's Date of Birth: _____

Secondary Insurance Company: _____

Subscriber: _____ Relationship to Patient: _____

Subscriber's S.S.N.: _____ Group #: _____

Subscriber's Date of Birth: _____

Assignment and Release

I, the undersigned certify that I (or my dependant) have insurance coverage with (name of insurance company) _____ and assign directly to Hoffman Estates Dental Professionals all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Hoffman Estates Dental Professionals to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

Financial Responsibility Acceptance

We are concerned about your dental health. We look forward to helping you with your dental care. Please remember that your dental insurance is your responsibility, but we can help. Regardless of what we calculate as your dental insurance benefit in dollars, we must stress the fact that you, the patient, are responsible for total treatment fees. Even pre-estimates from your dental insurance company are not a guarantee of payment. You, the patient, are ultimately responsible for your total treatment fees. As a courtesy to you we will file all insurance claims for you. Please note that your insurance coverage is a contract between you and the insurance company. The treatment plan is based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make a payment. After this time all inquires (follow-up) on payments become your responsibility.

If your insurance company is requesting any additional information for any treatment that you have received, you will need to contact us to check if we have received the same request for information. Many insurance companies will only send requests to you, the insured, leaving it up to you to complete or forward to us.

I understand and accept that it is my responsibility to pay for all of my dental treatment rendered by South Schaumburg Dental Professionals, Ltd. D.B.A. (Doing Business As) Hoffman Estates Dental Professionals.

Signature_____Date_____