Yahara Dental S.C.
FAMILY • GENERAL • COSMETIC
THOR J. ANDERSON, DDS

## Patient Information (CONFIDENTIAL)

Name ____________________________________________ Birthdate __________________________

Address __________________________________________ Home Phone ________________________

City _______________________ State ______ Zip ___________

Cellular _______________________ I would like to receive appointment reminders via text message Yes No

E-Mail ________________________________ I would like to receive appointment reminders via e-mail Yes No

Check Appropriate: ____Minor ____Single ____Married ____Divorced ____Widowed ____Separated

Patient or Parent Employer ________________________________ Work Phone ____________________

Spouse or Parent's Name __________________________________ Work Phone ____________________

Person to Contact in Case of Emergency _______________________________ Phone ________________

Whom May We Thank for Referring You? ____________________________________________________

## Insurance Information

Name of Insured _____________________ Relationship to Patient _____________ Birthdate __________

Name of Employer ________________________________ SSN # _______________________________

Insurance Company ______________________________________________________________________

Insurance Co. Address ___________________________ City ____________ State ____ Zip _________

Group # ______________________________ ID # __________________________________________

## Secondary Insurance (if applicable)

Name of Insured _____________________ Relationship to Patient _____________ Birthdate __________

Name of Employer ________________________________ SSN # _______________________________

Insurance Company ______________________________________________________________________

Insurance Co. Address ___________________________ City ____________ State ____ Zip _________

Group # ______________________________ ID # __________________________________________

## Authorization

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to my dentist and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits. If I have no dental insurance, I understand I am responsible for the full amount of my bill.

__________________________________________ __________________________________________

Signature Date

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