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

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____

Preferred name_____ Pronouns: He She They

Address _____ Home Phone _____

City _____ State _____ Zip _____ Work Phone_____

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

Spouse or Parent's Name _____

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 # _____

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

I acknowledge that I was offered a copy of Yahara Dental, S.C. Notice of Privacy Practices.

_____ _____

Signature Date

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke them in writing.

Name(s):_____

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