

Today's Date: _____

The Dental Center

815 38th Street SE, Cedar Rapids, IA 52403

(319) 365-0534 phone / (319) 297-7417 fax / info@crdentalcenter.com email

Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT

Patient's Legal Name: _____ I Prefer to be Called: _____ Male: _____ Female: _____

Birthdate: _____ Age: _____ SS #: _____ DL #: _____ Email: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Hm #: (____) _____ Cell #: (____) _____ Appointments Should be Confirmed at: Cell: _____ Hm: _____ Wk: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____ Separated: _____ Person Responsible for Account: _____

Your Employer: _____ Job Title: _____ Wk #: (____) _____ Ext _____

Employer Street Address: _____ City: _____ State: _____ ZIP: _____

New Patients: Which of our doctors do you prefer to see for your dental care? (choose one)

Chris Haganman, DDS, MS: _____ Brad Stovie, DDS: _____ Shannon Hingst, DDS: _____ No Preference: _____

Previous/Current Dentist: _____ Last Visit Date: _____ How did you hear about us? _____

Other Family Members Seen by Us: _____

SPOUSE

Legal Name: _____ Birthdate: _____ SS #: _____ DL #: _____

Cell #: (____) _____ Employer: _____ Job Title: _____ Wk #: (____) _____

Employer Street Address: _____ City: _____ State: _____ ZIP: _____

DENTAL INSURANCE (Primary)

Insured's Name: _____ Relation: _____ Insured's Birthdate: _____ SS#: _____

Insured's Employer: _____ Insurance Co: _____ ID: _____ Group #: _____

Ins Co. Address: _____ City: _____ State: _____ ZIP: _____ Phone: (____) _____

DENTAL INSURANCE (Secondary)

Insured's Name: _____ Relation: _____ Insured's Birthdate: _____ SS#: _____

Insured's Employer: _____ Insurance Co: _____ ID: _____ Group #: _____

Ins Co. Address: _____ City: _____ State: _____ ZIP: _____ Phone: (____) _____

CONTACT IN CASE OF EMERGENCY (other than spouse)

Name: _____ Relation: _____ Cell #: (____) _____ Hm #: (____) _____ Wk #: (____) _____

I authorize the following to have access to my billing, appointment, and treatment information (person responsible for account must be listed)

Name: _____ Relation: _____ Name: _____ Relation: _____

I understand that the information I have given today is correct and to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

I understand I am responsible for payment of services at the time they are rendered. If this office participates with my insurance, I understand I am also responsible to pay any co-payment and deductible at the time the service is rendered.

This office reserved the right to verify the credit status of patients and/or parents of minor patients.

Signature: _____

Date: _____