Highlands Dental

Last Name: _____
First Name: _____ Initial: ___
Date of Birth: _____
☐Male ☐Female
If child, parent's name: _____
Street Address: _____
City: _____ State: ___ Zip: _____
Home Phone: _____
Cell Phone: _____
Email Address: _____

Person responsible for this account
Name: _____
Employer: _____
Business Address: _____
Business Phone #: _____
Social Security #: _____
Drivers License #: _____

Someone to notify in case of emergency not living with you: _____

How did you hear about us?
_____

Dental Insurance
Primary
Subscriber Name: _____
Date of Birth: _____

Employer Name: _____
Insurance Company Name: _____
Phone: _____

Coverage Effective Date: _____
Subscriber ID # _____
Group # _____

Secondary
Subscriber Name: _____
Date of Birth: _____

Employer Name: _____
Insurance Company Name: _____
Phone: _____

Coverage Effective Date: _____
Subscriber ID # _____
Group # _____

Consent:
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I consent to the disclosure of my records (or my child's records) to those 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 it in writing.

I authorize payment directly to Highlands Dental of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payer.

I attest to the accuracy of the information on this page.

_____ _____
Signature Date

_____
Print Name