Highlands Dental

Patient Last Name: _____
First Name: _____
Date of Birth: _____
☐Male ☐Female
If minor, parent's name: _____

Address: _____
City: _____ State: ___ Zip: _____
Cell Phone: _____
Home Phone: _____
Email Address: _____
Social Security #: _____
Drivers License #: _____

Who should we notify in case of emergency?:
_____
Phone: _____

How did you hear about Dr. Burger?
_____
_____
_____

Dental Insurance

Primary

Subscriber Name: _____
Date of Birth: _____

Employer Name: _____
Insurance Company: _____
Phone: _____

Subscriber ID or SSN #_____
Group # _____

Secondary

Subscriber Name: _____
Date of Birth: _____

Employer Name: _____
Insurance Company: _____
Phone: _____

Subscriber ID or SSN #_____
Group # _____

Consent:

I consent to the diagnostic procedures and treatment advised by Dr. Burger necessary for proper dental care.
I consent to Dr. Burger'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 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