Fischer Family Dentistry

Medical Arts Building
2337 G. St., Suite 3
Belleville, KS 66935
785-527-5602
josephfischerdds.com

PATIENT NAME (LAST, FIRST, M.I.)		ADDRESS	
PARENT(s) OR GUARDIAN (IF PATIENT IS UNDER 19)		CITY STATE ZIP	
HOME PHONE NO	OFFICE PHONE NO.	CELL PHONE NO.	SOCIAL SECURITY NO.
MARITAL STATUS / SEX	BIRTHDATE	How did you hear about our office?	

ACCOUNTING INFORMATION

Billing Address (If different than above)_____

PLEASE NOTE- THE RESPONSIBLE PARTY (LEGAL GUARDIAN/PARENT) WHO SIGNS THE BELOW SIGNATURE IS WHO WILL RECEIVE THE BILL AND IT IS THAT INDIVIDUAL'S RESPONSIBILITY TO SEE THAT THE ACCOUNT BALANCE IS PAID IN FULL.

Patient's Occupation (or parent/legal guardian if patient is a minor):_____

Employer_____ **Employer's Address**_____

Spouse's Employer **Employer's Address**

INSURANCE INFORMATION

Do You Have Dental Insurance Coverage? YES NO Secondary Insurance Coverage? YES NO

Benefits Are Provided by Who?(circle) Myself My Spouse(Name)__ _____
Parent/Legal Guardian (Name)_____

Policyholder's Social Security Number: _____Policyholder's Date of Birth:_____

Insurance Group Number:_____ Identification Number:_____

Name of Insurance Company (please provide copy of card):

I authorize Fischer Family Dentistry to release any/all information requested by the Insurance Company. I give consent for Fischer Family Dentistry to render dental treatment including any and all anesthetics and/or medications to the above named Patient and authorize that I am 18 years or older or a parent/legal guardian which allows me to give this consent. I have read and signed a copy of Fischer Family Dentistry's Privacy Practice Notice. Furthermore, I UNDERSTAND THAT A 24 HOUR CANCELLATION NOTICE MUST BE GIVEN IF AN APPOINTMENT IS TO BE CANCELLED.

_____ _____

DATE SIGNATURE OF PATIENT, PARENT/LEGAL GUARDIAN