Dental Insurance Information

We are pleased to welcome you to our office. Please take a few minutes to completely fill out this form. If you have any questions we'll be glad to help you. The following information will be confidential.

1. Patient Information

Patient Name ____________ Date of Birth ____________ Social Security # ____________

2. Subscriber Information

Your relationship to subscriber: Self ☐ Spouse ☐ Child ☐

Subscriber Name ____________ Subscriber's Date of Birth ____________ Subscriber's SS # ____________

Insurance Company ____________ Group Number ____________ I.D. # ____________

Is patient covered by additional insurance? ☐ Yes ☐ No *If yes, please proceed to Section 3

3. Secondary Insurance Information

Your relationship to subscriber: Self ☐ Spouse ☐ Child ☐

Subscriber Name ____________ Subscriber's Date of Birth ____________ Subscriber's SS # ____________

Insurance Company ____________ Group Number ____________ I.D. # ____________

4. Assignment & Release

I certify that I and/or my dependent(s) have insurance coverage with ________________ (insurance company) and assign directly to Dr. Joel Umali, all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient Name (Please Print) ____________ Patient Signature ____________ Date ____________

Guardian or Responsible Party (Please Print) ____________ Guardian or Responsible Party Signature ____________ Date ____________

Consent for Treatment

Please read the following information and ask any questions you might have before signing the consent for treatment.

1. I hereby authorize Dr. Umali or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ____________________________’s dental needs.

2. Upon such diagnosis, I authorize Dr. Umali to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

______________________________	______________________________	____________
Patient Name (Please Print)	Patient Signature	Date
______________________________	______________________________	____________
Guardian or Responsible Party (Please Print)	Guardian or Responsible Party Signature	Date