OLIN DENTAL GROUP
WELCOME TO OUR PRACTICE

PATIENT INFORMATION:
Mr., Mrs., Ms., Dr. ***First Name*** _____M.I.____ ***Last Name***_____
Sex: Male, Female ***Birth Date***_____ ***Age***_____ ***Soc. Sec. #:*** _____
Minor, Single, Married, Long Term Partner, Divorced, Widowed, Separated
E-Mail_____ Cell ***#*** _____ ***Home #*** _____
Home Address _____
Nearest Relative to Contact_____ Contact's Phone #_____
How did you find out about our dental office**?** Insurance Website, Our Website, Family, Friend, Coworker, Past by our Building, Advertisement, Referring Doctor
Who referred you to us? _____
Employer_____ Business #_____
WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT? : Self, Spouse, Parent, Grandparent, Other
Person Responsible for Account _____
Their Birthdate_____ Their Social Security # _____
Their phone #_____
Their address _____
PRIMARY DENTAL INSURANCE: (We don't participate with HMOs or Medicaid)
Name of Insured_____ Relationship to patient _____
Employer_____
Bus. Address _____
Bus. Phone _____ Insurance Co. _____
Insurance Address _____ Insurance Phone _____
Insured ID# _____Group # _____ Group Name _____
Insured Date of Birth _____ Insured S.S. # _____
SECONDARY DENTAL INSURANCE: (We don't participate with HMOs or Medicaid)
Name of Insured_____ Relationship to patient _____
Employer_____
Bus. Address _____
Bus. Phone _____ Insurance Co. _____
Insurance Address _____ Insurance Phone _____
Insured ID# _____Group # _____ Group Name _____
Insured Date of Birth _____ Insured S.S. # _____

RELEASE OF INFORMATION: I hereby authorize the Olin Dental Group to release any necessary patient information to third parties such as medical, insurance, accounting, or legal representatives in order to correspond properly for business and medical reasons and process my claims. I understand that all personal and medical information will be held securely within the guidelines of the HIPAA laws; a copy of which is posted in the reception area for review and a personal copy can be had upon request.
PAYMENTS: I guarantee payment in full to the Olin Dental Group for the services rendered on my behalf or my dependents. I am financially responsible for all charges regardless how much coverage the insurance company may provide. The Olin Dental Group will honor any participating agreements with insurance companies which will be reflected on the billing statements. I understand that there may be a balance due after the insurance payment has been made even after an estimated copayment has been provided. It is necessary to pay any deductible and estimated copay at the time the services are rendered. The patient will be responsible for all collection costs, attorney fees and court costs if the bill remains unpaid.

I acknowledge that the above information is true and accurate and I also authorize the use of this signature on all insurance submissions.

Name of Patient or Parent if Minor (Please Print) _____
Signature of Patient or Parent if Minor _____ Date _____