

Dr. Richard D. Saunders DDS
Dr. Ryan R. Saunders DDS
Patient Information

Name of Patient _____ Male _____ Female _____
Date of Birth _____ Patient SSN _____ - _____ - _____
Relationship to Resp. Party _____ Previous Dentist _____
Date of Last Visit _____ Referred By _____
In case of Emergency, who should we contact? _____

Insurance Information

Primary Insurance _____	Secondary Insurance _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Customer Service (____) _____	Customer Service (____) _____
Insured's Name _____	Insured's Name _____
Employer _____	Employer _____
Emp. Address _____	Emp. Address _____
City, State, Zip _____	City, State, Zip _____
Group # _____	Group # _____
Insured's Birthday _____	Insured's Birthday _____
Insured's SSN _____	Insured's SSN _____

Responsible Party Information

Name _____	Home Phone _____
Address _____	Business/Cell Phone _____
City, State, Zip _____	Social Security # _____ - _____ - _____

Authorize to Release Information

Disclosure and authorization to release information. I hereby authorize any insurance company, prepayment organization, employer, or dentist to release all information with respect to myself or any of my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

I understand that insurance is a contract between me and my insurance company and that I am solely responsible to the dentist for payment of my account.

I also understand that if credit is extended, a finance charge of 1.5 percent per month will be added to any balance not paid in full within 60 days.

In the event that this account is turned over for collection, I agree to pay all collection fees, all court costs and reasonable attorney fees in the event of suit of referral for collection.

I hereby assign all dental and/or surgical benefits, to include major medical benefits, to which I am entitled including private insurance and other health plans to Dr. Richard Saunders and/or Dr. Ryan Saunders. A copy of this assignment will be considered binding. This assignment will remain in effect until revoked by me in writing.

Signature _____ **Date** _____