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? _____

Email Address_____

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 herby 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**_____