

# BLUE DIAMOND FAMILY DENTAL, S.C.

1502 MAIN STREET • BLOOMER, WI 54724

(715) 568-2363

DATE \_\_\_\_\_ ACCOUNT NUMBER \_\_\_\_\_

## PATIENT INFORMATION

Patient Name \_\_\_\_\_ Nick Name \_\_\_\_\_ Phone \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex M \_\_\_\_\_ F \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_

Employed by \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Text Reminder Yes \_\_\_\_\_ No \_\_\_\_\_ Email \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Birthdate \_\_\_\_\_

Spouse Employed by \_\_\_\_\_ Work Phone \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Have you or other family members been in our office? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, name \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Name of insurance company \_\_\_\_\_ Group Number \_\_\_\_\_

Identification Number \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

Subscriber \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Employer \_\_\_\_\_

Social Security # \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

Name of insurance company \_\_\_\_\_ Group Number \_\_\_\_\_

Identification Number \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

Subscriber \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Employer \_\_\_\_\_

Social Security # \_\_\_\_\_

## EMERGENCY CONTACTS

Nearest relative or friend not living with you whom we can contact in an emergency.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## FINANCIAL AND INSURANCE ARRANGEMENTS

Payment is expected at the time of service, at which time you will receive 5% discount for payments made in full. Visa and Mastercard is available. Financial agreements can be made with payment plans.

As an added service to you, your insurance claim will be processed by our office. I understand that I am responsible for all charges not covered by my dental insurance. I authorize the release of any information to the insurance carrier. I also authorize the insurance payment direct to Blue Diamond Family Dental, S.C. from my insurance carrier for their performed services.

I hereby authorize and consent to the performance of dental treatment which the dentist and I agree is necessary. A \$5.00 monthly rebilling charge will be added to all outstanding balances over 90 days old.

Patient or subscriber, parent \_\_\_\_\_ Date \_\_\_\_\_