Eugene Dental Associates

Peter C. Snyder D.D.S, Leah Hickson D.D.S.
Holly Park-Nah D.D.S., Endodontist

PATIENT INFORMATION

Patient's Name: _____
Last First Middle (Preferred Name)

Address_____City_____State_____Zip_____

Birth Date_____ Male_____ Female_____ SS# _____-_____-_____

Home Phone # _____ Ok to Leave a Message? **Yes/ No**

Cell Phone # _____ Ok to Leave a Message? **Yes/ No**

Work Phone # _____ Ok to Leave a Message? **Yes/ No**

Email Address:_____

May we discuss treatment with anyone? **Yes/No** Name: _____

Whom may we thank for referring you to our office?_____

RESPONSIBLE PARTY/ BILLING INFORMATION

Same as Above? **Yes/ No** If No please fill out below

Name: _____

Address_____City_____State_____Zip_____

Home phone # _____ Cell phone # _____

Birth Date:_____ Relationship to Patient: _____

If patient is a minor, guardian's name_____

DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ Birth Date:_____

SS#_____-_____-_____ Subscriber's Employer:_____

Insurance Company: _____Group#: _____ ID#_____

Insurance Address: _____ Phone # _____

Do you have Dual Insurance Coverage? Yes/ No

Subscriber's Name: _____ Birth Date:_____

SS#_____-_____-_____ Subscriber's Employer:_____

Insurance Company: _____Group#: _____ ID#_____

Insurance Address: _____ Phone # _____

CONSENT FOR TREATMENT

I hereby authorize Eugene Dental Associates/Peter C. Snyder D.D.S, P.C. to administer any treatment, x-rays, anesthetics and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I authorize release of any information relating to this claim. I realize that I am ultimately responsible for ALL costs of treatment. I understand the use of anesthetic agents embodies certain risks. I hereby authorize my insurance benefits to be paid directly to Eugene Dental Associates/ Peter C. Snyder D.D.S, P.C. and/ or a provider of record. After initial x-rays and exam we will give you an ESTIMATE of fees to cover your treatment. At that time financial arrangements will be made before treatment is rendered.

SIGNATURE: (patient or parent for minor)_____ DATE_____

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