

**Drs. Zunger and James, LLP**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First

If Child: Parent's Name \_\_\_\_\_

Residence - Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Bus. \_\_\_\_\_ Cell # \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: S M D W Spouse's Name \_\_\_\_\_

Patient/Parent Employed By \_\_\_\_\_

Patient/Parent SSN \_\_\_\_\_ Spouse/Parent SSN \_\_\_\_\_

Whom may we thank for this referral \_\_\_\_\_

Emergency Notification (Name & Tel # of nearest relative **not** living with you) \_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name & Address \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Social Security No. \_\_\_\_\_ Member ID NO. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name & Address \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Social Security No. \_\_\_\_\_ Member ID No. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

My consent to disclosure of records shall be effective until I revoke it in writing.

- I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
- I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
- I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits, if any, may be less than the actual bill for services, and that I am personally responsible for payment in full. By signing this statement, I agree to be responsible for payment for services not paid by my dental care payor, if any.
- I further understand that all responsibility for payment for dental services provided in this office for me or my dependent(s) is mine, due and payable at the time services are rendered unless other arrangements have been made.
- I understand that there is a \$25 bank fee for returned checks. The check must be picked up personally and cash must be paid to cover the check and the fee.
- I understand that I am responsible for all collection fees if this account becomes delinquent.
- I attest to the accuracy of the information on this page.

PATIENTS'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_