

New Patient Information

Patient's Name _____ Date of Birth _____ Age _____ Sex _____
Address _____ Apt# _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Extension _____
Employer _____
Employer Address _____
Social Security # _____ Driver's License (State & #) _____
Email Address _____

*** If the patient is a minor, please complete the following:**

Guardian _____ Relationship _____
Address _____ Apt# _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Extension _____
Employer _____
Employer Address _____
Social Security # _____ Driver's License (State & #) _____
Email Address _____

Emergency Contact

Name/Relationship _____ / _____ Daytime Phone: _____
Address _____ City _____ State _____ Zip _____

Insurance Information

Medical

Insurance Co. _____
Address _____

Phone Number: _____
Insured Party Name _____
S.S. # _____ D.O.B. _____

Dental

Insurance Co. _____
Address _____

Phone Number: _____
Insured Party Name _____
S.S. # _____ D.O.B. _____

Fees & Payments

Payment is expected prior to scheduling treatment to reserve your time. You may request pre-determination of your insurance benefits prior to treatment; however, this will usually delay treatment 30 days and will not change the amount they ultimately pay. **The office files your insurance as a courtesy, but you are responsible for full payment of your account.**

I hereby authorize the release of information necessary to process the claim(s). I authorize the use of this signature on all of my insurance claims, manual or electronic. I further authorize payment to the Dental Implant Center of Vero Beach the benefits otherwise payable to me. I understand that I am responsible for the payment of services rendered in full, regardless of payments expected by an insurance company.

Signature _____ Date _____
If Minor, Parent or Guardian

Consent and Diagnostic Aids

I hereby give my consent to T. Keith Grove, D.D.S., M.S. for any diagnostic aids necessary to evaluate, document and/or diagnose my condition. These shall include, but are not limited to, radiographs, models, and photographs. I further give Dr. Grove permission to use such data in any future research publication. I also release to Dr. Grove any medical or dental information necessary to evaluate and/or treat my condition.

Signature _____ Date _____
If Minor, Parent or Guardian