ITC Dental
Implant Center & General Dentistry

PATIENT INFORMATION

Date: _____

SS/Patient ID: _____

First Name: _____

Last Name: _____

Middle Initial : _____

Address : _____

City: _____

State: _____Zip: _____

E-Mail: _____

Sex: ☐ M ☐ F Age: ____ Birth date: _____

☐ Married ☐ Single ☐ Minor ☐ Other

Occupation : _____

Employer/School: _____

Employer/School Address: _____

_____

PHONE NUMBERS

Home: ( )_____ Cell: ( )_____

Pharmacy: _____ Phone: ( ) _____

Location: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Home Phone: ( )_____

Work Phone: ( )_____ Cell: ( ) _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co.: _____

Member ID _____

Group #: _____

Subscriber's Name: _____

Birth Date: _____ SS#: _____

Is patient covered by additional insurance? _____ Yes ____ No

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____

Name of Insurance Company (ies)

And assign directly to Dr. Ivan Teran Casabianca all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my healthcare information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This content will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Beneficiary, Guardian or Personal Representative

_____

Please Print Name of Beneficiary, Guardian or Personal Representative

Date: _____ Relationship to Beneficiary: _____

PREVIOUS DENTIST

Previous Dentist name: _____ Phone Number: ( )_____

Last dental exam: _____ Last Dental Cleaning: _____

Comments/Concerns for today's visit:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or dental insurance coverage. It is my responsibility to be aware of my eligibility and coverage with the above named insurance Company, and I understand that my dental insurance may only provide coverage for only the minimum standard of care. I elect to follow Dr. Teran's recommendations for optimal dental treatment. I understand that ITC Dental is confirming my dental benefits and billing my insurance for treatment as a courtesy, and declined claims for payment will become patient responsibility.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Please Print Name of Patient, Guardian or Personal Representative **Relationship To Patient**