

Powell Dental Group LLC, 39 Clairedan Drive Powell, OH 43065, 614-436-4433

Thank you for choosing Powell Dental Group for your dental needs. Please print and complete this form in ink for each member of your family. If you have any questions or concerns, do not hesitate to ask for assistance.

Patient Information

Date: _____

(please print)

Patient Name _____

First MI Last

Patient Email _____

Address _____ City _____ State _____ Zip _____

Birthdate ____/____/____ SS# _____ - _____ - _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Cell Phone (____) _____ - _____ Okay to send text message? Y / N

Can message be left? Home Y / N Work Y / N Cell Y / N

Where do you prefer to receive calls / confirmation of appointments? _____

Patient's Occupation _____

Employer Name _____

Spouse / Parent / Legal Guardian Name _____

Phone (____) _____ - _____

Person to contact in case of emergency _____

Phone (____) _____ - _____ Relationship _____

If patient is a student, name of school/college _____

If in college, school city / state _____ FT or PT (please circle one)

Responsible Party

Name of responsible party _____ Occupation _____

Relationship to patient _____ SS# _____ - _____ - _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone (____) _____ - _____

Employer Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you? Personal Referral by _____

Internet Insurance Provider Yellow Pages Suburban News Community Activity

Health Information Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my or my family member's health. It is my responsibility to inform the dental office of any changes in my, my spouse or my child's medical status. I also authorize the dental staff to perform the necessary dental services that myself, spouse, family member or my child may need. A separate itemized consent form is available for each treatment procedure and kept in the patient chart _____ Date _____

Signature of Patient / Parent / Guardian

Insurance Information

Primary Insurance

Name of Insured _____ Birthdate ____/____/____
Relationship to patient _____ SS# _____ - _____ - _____
(needed for insurance filing and verification only; this information is secure and confidential)
Phone (____) _____ - _____
Address _____ City _____ State _____ Zip _____
Employer _____ Work Phone (____) _____ - _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Phone (____) _____ - _____
Group # _____ Member ID# _____

Secondary Insurance

Name of Insured _____ Birthdate ____/____/____
Relationship to patient _____ SS# _____ - _____ - _____
(needed for insurance filing and verification only; this information is secure and confidential)
Phone (____) _____ - _____
Address _____ City _____ State _____ Zip _____
Employer _____ Work Phone (____) _____ - _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Phone (____) _____ - _____
Group # _____ Member ID# _____

Insurance Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in my, my spouse or my child's insurance status. I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to myself, spouse or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Date _____
Signature of Patient / Parent / Guardian

I authorize any representative from a third party administrator (ex: flex spending, FSA accounts) to speak with Powell Dental Group regarding insurance payments if applicable.

Date _____
Signature of Patient / Parent / Guardian