St George Family Dental
Matthew P St George DDS
603 Nichols St. Fulton, MO 65251
573-642-6904
www.stgeorefamilydental.com

Insurance Information

(Skip to consent at bottom of page if no insurance coverage)

Policy Holder's Name: ____

Policy Holder's Employer: ______________________________

Employer Phone #: _________________

Policy Holder's Social Security #: ___________________________

Dental Insurance Company: ______________________________________

Insurance ID #: ____________________________ Group #: ______________________________

Coverage Type (check one):

Family ____ Self & Dependents _____ Self Only _____

Children Only _____ Parents Only _____

Patient Birthdate: ______________________ Insured Birthdate: _________________________

Consent for Services

The information I provided is true and complete to the best of my knowledge. I agree to pay my co-payment at the time the services are rendered. I authorize release of any information needed for insurance or referral purposes. I agree to pay any fees unpaid by insurance and any fees for attorney/court costs or other fees that occur associated with non-payment of this account.

The doctor is not responsible for completion of treatment if I consistently fail to keep scheduled appointments.

I hereby give St. George Family Dental permission to use my likeness and photographs of dental treatment in a professional manner for promotional and educational purposes. i.e. posters, video presentations, etc.… as we see fit.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the above have been answered to my satisfaction and I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Parent Signature: ______________________________ Date:_______________