Randal P. Garvey, DDS, LLC

New Patient Information

Last Name: _____ First Name: _____ Title: _____
Middle Name: _____ Name you prefer to be called: _____
Home Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ May we call you at work? _____
Email Address: _____
Social Security Number: _____ Date of Birth: _____
Spouse Name: _____ Marital Status: _____ Gender: _____
Employer Name and Address:
_____
_____
Whom can we thank for referring you? _____
Mother's Maiden Name: _____
Nearest Relative NOT living with you: _____ Relationship: _____
Relative's Address: _____ Phone #: _____

PRIMARY INSURACE COVERAGE

Policy Holder Name and Address:
_____
_____
Relationship to patient: _____ S.S. #: _____ D.O.B: _____
Employer Name and Address:
_____
_____
Insurance Company Name and Address:
_____
_____
Group #: _____ Family Deductible: _____ Individual Deductible: _____

SECONDARY INSURANCE COVERAGE

Subscriber Name and Address: _____
Relationship to Patient: _____ S.S. #: _____ D.O.B: _____
Employer Name and Address: _____
Insurance Company Name and Address: _____
Group #: _____ Family Deductible: _____ Individual Deductible: _____

I understand that payment is expected at the time dental treatment is provided, if I have dental insurance you will submit my dental claim as a courtesy to me, but I am responsible for any co-payment at the time of service. I further understand if after 30 days my insurance company has not paid my claim I am responsible for any past due balance and assume responsibility of contacting and resolving insurance issues. I agree to pay a finance charge on the balance of my account at the rate of 1.5% per month. I also authorize the release of any information which may be reasonably needed to facilitate the collection of any delinquent balance either by the dentist or an authorized agent acting in the dentist's behalf.

Signature: _____Date: _____