WESTBANK DENTAL

3300 Bee Caves Road Suite 290 Austin, TX 78746

Name: _____ Preferred Name: _____ Date:_____

Email: _____ Male / Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Marital Status: Single / Married / Divorced / Widowed

Social Security No.: _____ Driver's License No.: _____

Person Responsible for Account: _____ Phone No.: _____

Address (if different from above) _____

Emergency Contact: _____ Phone No.: _____

I give permission for my medical/dental information to be shared with: _____

Relationship to patient: _____ Phone number: _____

Family Members Who Are Also Patients Here: _____

INSURANCE INFORMATION

Subscriber Name (if different from patient): _____ Subscriber's DOB: _____

Insurance Carrier: _____ Employer: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Group No.: _____ Subscriber's SSN: _____ Dual Coverage? Y N HSA or FSA Account? Y N

How did you hear about us?_____

CONSENT

_____(Initials) I authorize the dentist and staff to perform necessary diagnostic procedures and treatment for comprehensive and appropriate dental care.

_____ I authorize the release of my (or my child's) pertinent medical/dental information to my insurance company for the purpose of submitting insurance claims and receiving payment for completed dental work.

_____ I authorize the release of my (or my child's) medical/dental information to another dentist or healthcare professional when related to my dental treatment.

_____ I understand that payment in full is due at the time services are rendered. This includes any portion of my balance that insurance is estimated not to cover.

_____ I recognize that the amount I am told insurance will pay is only an estimate. I agree to be responsible for the balance not paid by insurance. This includes any procedure that is denied completely by the insurance company.

_____ I understand that Westbank Dental requires at least 24 hours of notice for all appointment cancellations. If I am unable to give 24 hours of notice, I will be billed $50 for the rescheduled or missed appointment. I certify that the above information is complete and correct.

Patient's signature: _____ Date: _____