The Dental Center

815 38th Street SE, Cedar Rapids, IA 52403
(319) 365-0534 phone / (319) 297-7417 fax / info@crdentalcenter.com email

Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT

First Name:_____ M.I._____ Last Name: _____ Preferred First Name: _____

Male:_____ Female:_____ Birthdate:_____ Age:_____ SS #: _____

Street Address: _____ City: _____ State: _____ ZIP:_____

Hm #: (____) _____ Cell #: (____) _____ Appointments Should be Confirmed at: Cell: ____ Hm: ____ Wk: ____

Single: ____ Married: ____ Divorced: ____ Widowed:____ Person Responsible for Account: _____

Your Employer: _____ Job Title: _____ Work #: (____)_____ Ext: _____

Employer Street Address: _____ City: _____ State: _____ ZIP:_____

New Patients: Which of our doctors do you prefer to see for your dental care? (choose one)

Chris Haganman, DDS, MS: _____ Brad Stovie, DDS: _____ Shannon Hingst, DDS: _____ No Preference: _____

Previous/Current Dentist: _____ Last Visit Date: _____ How did you hear about us? _____

Other Family Members Seen by Us: _____ _____ _____ _____

PERSON RESPONSIBLE FOR ACCOUNT

Legal Name: _____ Birthdate: _____ SS #: _____

Cell #: (_____) _____ Employer: _____ Job Title: _____ Wk #: (_____) _____

Employer Street Address: _____ City: _____ State: _____ ZIP:_____

DENTAL INSURANCE (Primary)

Insured's Name: _____ Relation: _____ Insured's Birthdate: _____ SS#: _____

Insured's Employer: _____ Insurance Co: _____ ID: _____ Group #:_____

Ins Co. Address: _____ City: _____ State: ____ ZIP: _____ Phone: (____) _____

DENTAL INSURANCE (Secondary)

Insured's Name: _____ Relation: _____ Insured's Birthdate: _____ SS#: _____

Insured's Employer: _____ Insurance Co: _____ ID: _____ Group #:_____

Ins Co. Address: _____ City: _____ State: ____ ZIP: _____ Phone: (____) _____

CONTACT IN CASE OF EMERGENCY (other than spouse)

Name: _____ Relation:_____ Cell #: (____)_____ Hm # (___)_____ Wk #: (____)_____

I authorize the following to have access to my billing, appointment, and treatment information *(person responsible for account must be listed):*

Name: _____ Relation: _____ | Name: _____ Relation: _____

I understand that the information I have given today is correct and to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

I understand I am responsible for payment of services at the time they are rendered. If this office participates with my insurance, I understand I am also responsible to pay any co-payment and deductible at the time the service is rendered.

I agree that the dental practice may communicate with me electronically at the e-mail address listed above on this form. I am aware that there is some level of risk that third parties might be able to read unencrypted e-mail. E-mail is not password protected. I am responsible for providing the dental practice any updates to my e-mail address. I can withdraw my consent to electronic communication by calling: 319-365-0534.

(Please initial if you agree to use electronic correspondence) _____ E-mail Address: _____

Signature: _____ Date: _____