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

Patient's Legal Name: ______________________ Preferred First Name: ____________ Male: _______ Female: _______

Birthdate: ____________ Age: ___ Person Responsible for Account: ________________ Phone # to Confirm Appointments: (____)______________

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: ______ 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 (If under 18, Mother and Father's information must be supplied.)

Legal Name: ____________________ Birthdate: ______________ SS #: ______________

Relationship to Patient: ______________ Home #:(____)__________ Cell #: (____)__________ Work #: (____)__________

Street Address: ______________________________ City: __________________ State: ______ ZIP: __________

Employer: ____________________ Job Title: ____________________

Employer Street Address: ____________________________ City: ________________ State: ______ ZIP: __________

Legal Name: ____________________ Birthdate: ______________ SS #: ______________

Relationship to Patient: ______________ Home #:(____)__________ Cell #: (____)__________ Work #: (____)__________

Street Address: ______________________________ City: __________________ State: ______ ZIP: __________

Employer: ____________________ Job Title: ____________________

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

Name: __________________ Relation: _____________ Cell #: (____) __________ Home #: (____) _________ Work #: (____)__________

The following are authorized to have access to 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 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 electronic communication) _______ **E-mail Address:** ________________________________

Patient Signature (or Guardian/Parent if under 18): ______________________________ **Date:** ______________

03/28/19