The Dental Center

815 38th Street SE, Cedar Rapids, IA 52403 -- (319) 365-0534
1090 Sherman Road, Hiawatha, IA 52233 – (319) 362-0043
(319) 297-7417 fax / info@thedentalcenter.dental 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: ___ Jenna Haganman, DMD: ___ 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: ________________