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

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: _____ 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 (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:** _____