Dental Insurance Information

Primary Insurance Company _____ **Ins. Phone Number** (_____) _____-_____

Subscriber Name_____ Date of Birth ____/____/____ Relation to Patient _____
Employer Name _____ Employer Address _____
Subscriber Social Security/ ID# _____ Group ID# _____

Secondary Insurance Company _____ **Ins. Phone Number** (_____) _____-_____
Subscriber Name_____ Date of Birth ____/____/____ Relation to Patient _____
Employer Name _____ Employer Address _____
Subscriber Social Security/ ID# _____ Group ID# _____

In order to prevent misunderstandings about dental insurance, please understand that this is an agreement between you, your employer and your insurance carrier, we cannot act as arbitrators in this manner. **Payment in full is due on your initial consultation (first visit), as well as your periodontal maintenance therapy.** After verification, we will accept assignment of benefits from your insurance carrier in surgeries and scaling & root planning. We will estimate your copayment prior to your treatment and is due the day service is rendered. We will file your insurance and prepare any necessary reports to help you attain the best benefits provided by your dental plan.

I authorize Dr. Mangelson to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis on my dental needs to perform any and all forms of treatment to include medication and therapy.

_____

Signature(Guarantor) **Date**

HEALTH QUESTIONAIRE ACKNOWLEDGMENT AND CONSENT TO PROCEED:

Patient's Name _____

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medication can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Mark L. Mangelson and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or other therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporarily or rarely, permanent numbness and muscle soreness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the forgoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature (Patient/legal guardian):_____ **Date:** _____

Witness: _____ **Date:** _____