LOCH
DENTAL CARE

Pyramid Mall Suite 789,
Routes 5 & 20, Geneva, NY
(315) 781-9040

Please Print *To be completed by parent/guardian if the patient is a minor.*

Patient's Full Name _____ Date of Birth _____
First Middle Last

Address_____City_____State_____Zip_____

Home Phone _____ Cell/Other Phone _____

If Patient is a minor, please provide Parent or Guardian Name: _____
First Middle Last

Social Security Number _____ Date of Birth _____Employer_____

Email Address _____ Name any other immediate family members who should be on the same account for billing purposes _____

How did you hear of **Loch Dentistry?** _____
If you were referred by a patient – PLEASE name them specifically so that we may thank them!

Do you have dental insurance? ❒ Yes ❒ No

	Primary Dental Insurance	Secondary Dental Insurance
Subscriber's name	_____	_____
Subscriber's Social Security #	_____	_____
Subscriber's Date of birth	_____	_____
Relationship to subscriber:	❒ self ❒ spouse ❒ child ❒ other	❒ self ❒ spouse ❒ child ❒ other
Subscriber's Employer	_____	_____
Name of Insurance Company	_____	_____
Phone Number (of ins. Co)	_____	_____

I authorize **Loch Dentistry to perform the necessary treatment plan.** Signature _____

I have received a copy of this office's Notice of Privacy Practices. Signature _____

I hereby authorize payment directly to **Loch Dentistry.** Signature _____

Payment Agreement I understand and agree that dental insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary forms to assist in making collection from the insurance company, if any, & that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are my financial responsibility. I understand and agree that this office, as a courtesy to me, will bill my insurance company, if any, for all services rendered to me. I understand that all co-payments/deductibles are due on the service date and agree to make such payments. I understand that if for any reason my insurance company fails to pay for any service rendered that I am personally responsible for payment and agree to make full payment within 30 days. In the event my account balance is referred to an agency or attorneys for collection purposes, I agree to pay reason able attorneys fees and any expenses or costs relating to the collection proceeding, including court costs. In the event that the patient is a minor, I am the parent and/or guardian of said patient and agree that I am responsible for all services rendered to the patient.

Signature _____ Date _____

Optional Credit Card Authorization

By signing hereunder, I authorize **Loch Dentistry to bill my credit card account should any balance for services rendered remain outstanding for more than sixty (60) days.**

❒ Visa ❒ Mastercard ❒ Discover ❒ American Express ❒ Care Credit

Account Number:_____ Expiration Date _____

Signature _____ Date _____