Lasting Impressions Dentistry

CONFIDENTIAL
Patient Information

David Loshin, DMD, PLLC

Legal Name First MI Last

Social Security number

date of birth

age

Name I prefer to be called

☐ male ☐ female

Other family members seen by us

Home address city state zip

Occupation

Employer address city state zip

How long?

1st preferred contact phone ☐cell ☐home ☐work

2nd preferred contact phone ☐cell ☐home ☐work

3rd preferred contact phone ☐cell ☐home ☐work

Email address

For appt. confirmations, I prefer: ☐ Email ☐ Phone ☐ Either one

Emergency contact name Phone

How were you referred to our practice?

Name of previous dentist Phone

Reason for last visit

Approx. date

Date last full x-rays

PRIMARY INSURANCE

If you have no insurance check here ☐

Name of Insured person

Employee Insur I.D. #

Relation eg. "Myself" "Spouse", "Son"

Insured's Date of birth

Insured's Phone

Insurance company

Phone

Address of Insurance company

Insured's Employer

Group / Policy #

SECONDARY INSURANCE

Name of Insured person

Employee Insur I.D. #

Relation eg. "Myself" "Spouse", "Son"

Insured's Date of birth

Insured's Phone

Insurance company

Phone

Address of Insurance company

Insured's Employer

Group / Policy #

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION

Name of Responsible party

Soc. Security Num.

Address city state zip

Relation eg. "Father", "Partner"

Cell Phone

Home phone

Employer

Work phone

ASSIGNMENT, CONSENT AND RELEASE

I authorize my dental insurance benefits to be paid directly to Lasting Impressions Dentistry and allow the release of any information about my treatment for purposes of filing dental benefit claims. I understand that the processing of insurance claims is a courtesy, and does not relieve me of my financial obligation to Lasting Impressions Dentistry. I am obligated to pay for all outstanding balances on my account regardless of slow insurance company processing, disputed claims, employer elegibility requests, information requests, lack of benefits, or other delays etc. Lasting Impressions Dentistry will accept Insurance Assignment in lieu of my personal payment for a maximum of 90 days. After 90 days all unpaid insurance claims are fully due and payable by me. I may file my own insurance claims and I understand that in such a case FULL PAYMENT AT TIME OF SERVICE IS REQUIRED. In the event any balance becomes 60 days overdue, billing may be turned over to an outside collection agency. The Responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. For education of other dental health professionals and patients, I give permission to use and display my x-ray or photo images in-office, on practice website, or in a professional journal. My full name will not be used. No other details may be used or given out (except for a descriptive summary of the images) without my additional permission. By signing below I also acknowledge that I have been provided with the Lasting Impressions Dentistry Notice of Privacy Practices.

Signature

Date