Cooley-Bentz Dental Associates, P.C.
Sara Cooley-Bentz, DMD, FAGD
2601 DeKalb Pike, East Norriton, PA 19401 • 610.272.6949 • Fax 610.272.8664 • www.cooleybentzdental.com

PATIENT INFORMATION *CONFIDENTIAL*

Name: _____ Date _____
FIRST MIDDLE LAST

Address: _____
STREET CITY STATE ZIP

CONTACT INFORMATION

Home: _____ Work: _____
Fax: _____ Cell: _____
Email Address: _____
Best day/time to be reached: _____ Where? _____
In the event of an emergency, who should we contact?
Name: _____
Relationship: _____
Work # _____ Home #: _____

Birthdate: _____

Minor Patients – A parent/guardian must accompany minors when services are being performed in our office. This adult is responsible for payment regardless of family status.

Patient's or Parent's Employer: _____ Occupation: _____

Business Address: _____
STREET CITY STATE ZIP

Spouse or Parent's Name: _____ Employer: _____ Work Phone: _____

If patient is a student, name of school/college: _____ City: _____ State: _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship: _____

Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Soc. Sec. #: _____ Birthdate _____

Driver's License #: _____

Employer: _____ Work Phone: _____

Is this person currently a patient in our office? ❍ Yes ❍ No

Continued on back ➔

INSURANCE INFORMATION

Name of insured: _____ Relationship: _____

Birthdate: _____ Soc. Sec. # _____ Date Employed: _____

Employer: _____ Work Phone: _____

Address of Employer: _____
STREET CITY STATE ZIP

Insurance Company: _____ Group #: _____

Do you have any secondary insurance?: ❍ Yes ❍ No If yes, complete the following:

Name of insured: _____ Relationship: _____

Birthdate: _____ Soc. Sec. #: _____ Employer: _____

Address of Employer: _____ Work Phone: _____

Insurance company: _____ Group #: _____

FINANCES

Payment in full is expected at each appointment. We have scheduled time in our schedule just for you, therefore, we require 48 business hours notice for any cancellation. If you miss your appointment, that time could have been allotted for another patient in need. There is a $30 service charge on all returned checks. For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

❍ Cash
❍ Personal Check
❍ Visa
❍ MasterCard
❍ Discover
❍ American Express
❍ Care Credit

Card #: _____

Exp. Date: _____

_____
NAME AS IT APPEARS ON CARD

Authorization, Release, & Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health practitioners.

As a courtesy, we will be glad to file insurance claims for you. Please note that insurance is a contract between you and your insurance company and we are not a party to that contract. You will be responsible to pay your first office visit in full, unless prior arrangements are made with our front desk staff.

I authorize and hereby request my insurance company to pay directly to the dentist for the dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____ _____
Signature of patient or parent if minor *Date*