Welcome to Abbott Family Dentistry LLC

Robert P. Pierson, DDS

PATIENT INFORMATION:

NAME: _____ SSN: _____

MAILING ADDRESS: _____ BIRTHDATE: _____

CITY: _____ STATE: ____ ZIP: _____ DRIVER'S LICENSE: _____

PHYSICAL ADDRESS: _____ HOME PHONE: _____

IF SAME AS MAILING, WRITE "SAME"

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ WORK PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: _____

AT WHICH NUMBER WOULD YOU LIKE US TO CONTACT YOU: _____

We will call you at the preferred number 2 days before your appointment to confirm.

In addition, as a courtesy, we can also notify you via text and/or e-mail. Please provide that information below:

CELL: _____ CARRIER: _____ E-MAIL: _____

IF YOU ARE A FULL-TIME STUDENT LIST UNIVERSITY & CITY: _____

WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

GUARANTOR: (PERSON RESPONSIBLE FOR PAYMENT) IF SAME AS ABOVE, WRITE "SAME"

NAME: _____ SSN: _____

ADDRESS: _____ BIRTHDATE: _____

CITY: _____ STATE: ____ ZIP: _____ DRIVER'S LICENSE: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ WORK PHONE: _____

CITY: _____ STATE: ____ ZIP: _____ CELL PHONE: _____

SPOUSE INFORMATION: IF SAME AS GUARANTOR, WRITE "SAME"

SPOUSE'S NAME: _____ SSN: _____

ADDRESS: _____ BIRTHDATE: _____

CITY: _____ STATE: ____ ZIP: _____ DRIVER'S LICENSE: _____

SPOUSE'S EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ WORK PHONE: _____

CITY: _____ STATE: ____ ZIP: _____ CELL PHONE: _____

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PRIMARY INSURANCE:

INSURANCE COMPANY: _____ PHONE: _____

GROUP NUMBER: _____ I.D. NUMBER (OR SSN): _____

NAME OF SUBSCRIBER: _____ BIRTHDATE: _____

SECONDARY INSURANCE:

INSURANCE COMPANY: _____ PHONE: _____

GROUP NUMBER: _____ I.D. NUMBER (OR SSN): _____

NAME OF SUBSCRIBER: _____ BIRTHDATE: _____

ASSIGNMENT AND RELEASE:

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH _____ AND THAT I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE CLAIMS SUBMITTED AND ASSIGN DIRECTLY TO DR. ROBERT P. PIERSON, AND/OR Abbott Family Dentistry LLC, ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE AND GIVE MY CONSENT FOR THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS. I AUTHORIZE AND GIVE CONSENT FOR DR. ROBERT P. PIERSON, AND/OR Abbott Family Dentistry LLC, TO CONTACT MY EMPLOYER TO VERIFY EMPLOYMENT AND ANY OTHER INFORMATION NEEDED TO VERIFY INSURANCE ELIGIBILITY AND BENEFITS.

SIGNATURE _____ DATE _____