BATTLE GROUND DENTAL
2312 W. Main Street, Suite 121 • Battle Ground, WA 98604
(360) 687-4721 • 1-888-875-9897

Welcome To Our Practice

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone _____ Other Phone _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Birthdate _____ E-Mail _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Subscriber's Name _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company Name and Address _____

_____ Group # _____ Phone # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company Name and Address _____

Soc. Sec. # _____ Group # _____ Phone # _____

Names of other dependents covered under this plan _____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I shall be responsible for any charges incurred,, including any charges not paid by my insurance company because of ineligibility, lack of coverage, non-covered charges, or charges over my yearly maximum.

_____ _____ _____
Patient Printed Name Patient Signature or Guardian Date

Payment is due in full at time of treatment unless prior arrangements have been approved.