John T. Carson, D.D.S., M.S., Inc.

PATIENT ACCOUNT AND INSURANCE INFORMATION

The benefits of a happy, healthy smile are Immeasurable! Our goal is to help you reach and maintain excellent oral health.
Please fill out these forms completely. The better we communicate, the better we can care for you.

About You

Name (last, first): ______________________ Age: ______ Date of Birth: ____________ ☐ Male ☐ Female

Address: ______________________ City: ______________ State: ________ Zip: ____________

Home Phone:(_______) ______________ Cell Phone/Pager: (______) ______________ E-Mail: ______________

Social Security Number: ______________________________

Employer: ______________________ Work Phone: (______) ______________ Ext: ____________

Employer Address: ______________________ City: ______________ State: ________ Zip: ____________

Person Responsible for Account

Name (last, first): ______________________________

Relationship of responsible party to patient: ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian

If responsible party is other than patient, please complete the remainder of this section.

Address: ______________________ City: ______________ State: ________ Zip: ____________

Home Phone:(_______) ______________ Cell Phone/Pager: (______) ______________ E-Mail: ______________

Social Security Number: ______________________________

Employer: ______________________ Work Phone: (______) ______________ Ext: ____________

Employer Address: ______________________ City: ______________ State: ________ Zip: ____________

Spouse Information

Name (last, first): ______________________________

Employer: ______________________ Work Phone: (______) ______________ Ext: ____________

In case of emergency, please contact:
(other than spouse)

______________ Name ______________ Relationship ______________ Phone

Dental Insurance

If you have dental and/or medical insurance, please complete this section. Insurance policies are contracts between you and your insurance company. We are happy to assist you with your claim forms, and your efforts to get appropriate coverage. To avoid misunderstandings regarding health insurances, our professional services are charged directly to you and you are personally responsible for payment of fees.

Primary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

City, State, Zip: ______________________

Insurance Co. Phone: (________) ______________

Group/Plan Number: ______________ I.D. Number: ______________

Insured's Name: ______________ Relationship: ______________

Insured's Date of Birth: ______________ Insured's SSN: ______________

Insured's Employer: ______________________

Secondary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

City, State, Zip: ______________________

Insurance Co. Phone: (________) ______________

Group/Plan Number: ______________ I.D. Number: ______________

Insured's Name: ______________ Relationship: ______________

Insured's Date of Birth: ______________ Insured's SSN: ______________

Insured's Employer: ______________________

CONSENT: The undersigned hereby authorizes the Doctor and staff to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

X ______________________________ ______________

Signature of Patient, Parent, or Guardian Date