



Welcome

Vadnais Heights Family Dentistry
1230 East County Road E
Vadnais Heights, MN 55110



Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

1. Responsible Party

Name

Date

I wish to be called

Date of Birth

Address

E-mail Address

Marital Status

Gender

Home Phone

Work Phone

Cell Phone

The best time to reach me

Preferred Number (home, work, or cell)

Driver License Nnumber

Social Security Number

Employer

Occupation

2. Emergency Contact

Name

Relationship

Home Phone

Work Phone

Cell Phone

3. Dental Insurance Information

Primary Insurance Company

Secondary Insurance Company

Primary Subscriber Name

Secondary Subscriber Name

Primary Subscriber Date of Birth

Secondary Subscriber Date of Birth

Primary Insurance ID Number

Secondary Insurance ID Number

Primary Group Number

Secondary Group Number

Primary Mailing Address

Secondary Mailing Address

Primary Maximum Annual Benefit

Secondary Maximum Annual Benefit

Amount of Maximum Already Used

Amount of Maximum Already Used

Primary Deductible

Secondary Deductible

4. Persons on This Account

_____ Name	_____ Date of Birth	_____ School
_____ Name	_____ Date of Birth	_____ School
_____ Name	_____ Date of Birth	_____ School
_____ Name	_____ Date of Birth	_____ School
_____ Name	_____ Date of Birth	_____ School
_____ Name	_____ Date of Birth	_____ School
_____ Name	_____ Date of Birth	_____ School
_____ Name	_____ Date of Birth	_____ School

5. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full is expected at each appointment.

Cash Personal Check Payment Plan
 Credit Card (Visa/Master Card/Discover/American Express)
 I wish to discuss the dental office's policy

Thank you for filling out this form completely. The information you provided will help us serve your dental healthcare needs more efficiently. If you have any questions at any time- please ask. We are always happy to help.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except dental emergencies where there is prepayment for additional services. In case of default on payment, I agree to pay collections cost and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature

Date

Who can we thank for referring your family to us?
