Account # ______________________________ ______________

PATIENT:

Last name______________________ First name__________________ M.I.______
Birthdate__________ Age__________ Marital status________________ Sex______
Street______________________City____________________ State_____ Zip______
Patient Email address ________________________ SS#____________________
Phone: Home____________ Work________________ Cell__________________
Occupation______________________ Employer______________________________
Employer Address____________________________________ Phone______________
Emergency Contact Person ____________________________ Phone______________

SPOUSE ☐ or PARENT ☐ INFORMATION: (please mark relationship)
Last name______________________ First name__________________ M.I______
Address_________________________City__________________State____Zip_______
Spouse / Parent Email Address ____
Telephone Home___________________ Work_______________________________
Employer____

Daytime Appointment Confirmation

Please mark preferred confirmation method

Phone call to Home ☐ Work ☐ Cell ____________________
Email to Patient ☐ Parent/Spouse ☐ ____________________
Text to Cell # ____________________________

How did you hear about our office? Internet Phone book Friend/Relative ________________

Dental Associates of Manhattan is a contracting provider for:
Delta Dental, Blue Cross-Blue Shield of Kansas & United Concordia.
Any other insurance will be Out of Network

We accept cash, check, MasterCard, Visa, Discover, and Care Credit.

It is understood that all professional services must be paid for at the time service is rendered unless specific prior arrangements are made with this office. It is the goal and responsibility of this office to provide the best dental care we possibly can. In return it is your responsibility to pay in full for this care.

This office will gladly assist you in the filing of your insurance claim. We ask that you provide us with the most accurate insurance information. Even though an insurance claim may be filed, you are still solely responsible for the total amount of your account. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Will you be using any dental insurance? Yes No

I have read and understood the information on this form.

Signature____ Date____________________