Welcome and thank you for selecting the BVDA as your dental healthcare team. We strive to provide you with the best possible dental care. To help us meet your entire dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Personal Information

Name _____Nickname _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ ext____
Birth Date _____ Social Security # _____
Male _____ Female _____ Marital Status _____
How did you hear of our practice? _____
In the event of an emergency, whom should we contact?
Name _____ Relationship _____ Home _____ Work _____

Primary Dental Insurance

Person responsible for payment or self_____
Name of Insured _____ Relationship to patient _____
Birth date _____ S.S. # _____Employer _____
Insurance Name _____ Insurance Address _____
Insurance Phone _____ Group Number _____ Subscriber ID _____

Additional Dental Insurance

Name of Insured _____ Relationship to patient _____
Birth date _____ S.S. # _____Employer _____
Insurance Name _____ Insurance Address _____
Insurance Phone _____ Group Number _____ Subscriber ID _____

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 during the period of such dental care to third party or 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 that if my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature _____ Date _____
I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempt to collect on this amount or any future outstanding account balances.
Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.