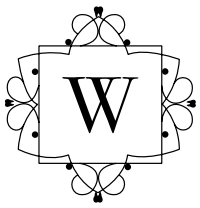

LEESBURG FAMILY & COSMETIC

D E N T I S T R Y

661 Potomac Station Drive, Leesburg, VA 20176
(703) 831-3952

Patient Information Form

Name: _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Other**
Date of Birth: _____ **SSN:** _____
Home #: _____ **Work #**:_____ **Cell #**:_____
Email address: _____
Mailing Address: _____
City: _____**State**: _____ **ZIP**: _____
Employer: _____

Who may we thank for referring you to our practice?

_____

Dental Insurance Information

Insurance Company Name: _____
Policy Holder/Subscriber Full Name: _____
Date of Birth: _____ **Relation to Policy Holder**: _____
Subscriber ID#: _____
Group/Employer Name: _____ **Group #**: _____
Claims Mailing Address:

_____

Insurance Phone #: _____

- I authorize release of any information concerning my/my child's healthcare recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.
- I authorize payment of insurance benefits directly to Leesburg Family and Cosmetic Dentistry.
- I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.
- I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment.
- I agree to pay any applicable deductibles and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.
- I agree to pay the total cost of dental services rendered on the date of service if I/my child does not have dental insurance benefits.

Patient/Guardian Signature: _____**Date**: _____