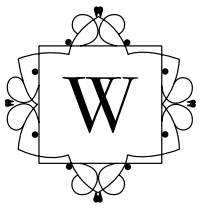

LEESBURG FAMILY & COSMETIC

D E N T I S T R Y

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

Patient Information Form

Name: _____ ☐**Male** ☐ **Female**

Mailing address: _____ **City**:_____ **State**:_____
ZIP:_____
Home
Phone:_____**WorkPhone**:_____**CellPhone**:_____
Email address: _____
Date of Birth: _____ **Social Security Number**:_____
Employer:_____

Who may we thank for referring you to our practice?_____

DENTAL INSURANCE INFORMATION

Employee/Subscriber Name: _____
Date of Birth: _____**Subscriber ID#**: _____
Group/Employer Name: _____ **Group Number**: _____
Insurance Company Name:
_____
Claims Mailing Address:_____
Telephone Number: _____

- 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**: _____