ROSS
FAMILY DENTISTRY

DERRICK K. ROSS, D.M.D.
Your Smile, Your Health, Our Commitment

Date _____

PATIENT INFORMATION

Name_____ SS # _____ I prefer to be called_____

Address_____ City_____ State_____ Zip_____

Sex ☐M ☐F ☐Married ☐Widowed ☐Single ☐Minor Birthdate _____

☐Separated ☐Divorced Home Phone ( ) _____

E-mail _____ Cell Phone #1 ( ) _____ Cell Phone #2 ( ) _____

Employer/School_____ Employer/School Phone ( ) _____

Employer/School Address_____ City _____ State _____Zip _____

Spouse or Parent's Name_____ Employer _____ Work Phone ( ) _____

Whom may we thank for referring you?_____

Other Family Members seen by us _____

Person to contact in case of emergency _____ Home Phone ( ) _____

Work Phone ( ) _____

Closest relative not living with you _____ Home Phone ( )_____

Work Phone ( ) _____

RESPONSIBLE PARTY

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone ( ) _____

Driver's License # _____ S.S.#_____ Birthdate _____ Bank _____

Employer _____ Work Phone ( ) _____

Currently a patient in our office? ☐Yes ☐No E-mail _____ Cell Phone ( ) _____

Have you or the responsible party ever filed bankruptcy? ☐Yes ☐No

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relation fo Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone ( ) _____

Employer Address _____ City _____ State _____Zip _____

Insurance Company _____ Group # _____ ID # _____

Address _____City _____ State _____ Zip _____

How much is your deductible? _____ Max. Annual Benefit _____ How much have you used? _____

(continue on the back side)

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relation fo Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ ID # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. Derrick K. Ross all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my and/or my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient