PRIME Dental
Dr. Tatiana Lucas, DDS
272 Cross Roads Plaza
Mount Pleasant, PA 15666

PATIENT INFORMATION FORM

Patient Name:_____

Work Phone :(____) _____

Birth Date: _____/_____/_____ Social Security # _____

Employer: _____

Home Address:_____

Occupation: _____

City: _____State: _____ Zip: _____

Employer Address: _____

Home#(____) _____ Cell#(____)_____

City: _____State: _____ Zip: _____

Marital status: Single ☐, Married ☐, Divorced ☐, Separated

M ☐ F ☐

Whom should we contact in case of an Emergency: _____

Phone: (_____) _____

Relationship to Patient: _____

How did you find out about us or Whom may we thank for referring you to our Prime Dental office**?**_____

Referred by a friend ☐, YellowPages ☐, Relative ☐, Newspaper Add ☐, Insurance Plan ☐, Direct Mailing ☐, Website ☐, Internet ☐

Other _____

Primary Dental Insurance:

Name of Insurance Co: _____

Name of Subscriber: _____

Relation of Subscriber to Patient: _____

Social Security # of Subscriber: _____

Group #: _____ DOB of Subscriber: ____/____/_____

Subscriber Employer : _____

Business address_____

City: _____State: _____ Zip: _____

Subscriber Occupation_____

Home address_____

City: _____State: _____ Zip: _____

Work phone_____Home phone_____

Cell phone _____

Secondary Dental Insurance:

Name of Insurance Co: _____

Name of Subscriber: _____

Relation of Subscriber to Patient: _____

Social Security # of Subscriber: _____

Group #: _____ DOB of Subscriber: ____/____/_____

Subscriber Employer : _____

Business address_____

City: _____State: _____ Zip: _____

Subscriber Occupation_____

Home address_____

City: _____State: _____ Zip: _____

Work phone_____Home/Cell_____

Cell phone _____

We need the above information so that we can help obtain the dental insurance benefits you are eligible for. This may require submitting the Doctor's treatment plan to the insurance company(s) for a pre-determination of benefits, or in some cases obtaining the information by phone and internet. We can NEVER guarantee payment by your insurance company. The insurance company's contract is with you and your employer.

Consent, Policies and Procedure

I understand all payments are due at the time of service, unless prior arrangements have been made. The financial responsibility of each patient for the planned services will be determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for at the time service performed. I understand and agree that, regardless of my insurance status, that dental services provided to me are charged directly to me and that I am ultimately responsible for the balance on my account. If I carry insurance, I understand that Prime Dental office will help prepare my insurance forms to assist in making collections from my insurance company and will credit such collections to my account. However, I understand that Prime Dental office will not render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and authorize my insurance company to pay directly to Prime Dental benefits accruing to me under my policy. I understand that the fee estimate listed for my dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, if such occurs, my credit history may be checked through the use of my Social Security number or any other information provided by me. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for the services rendered, the prevailing party in such proceedings shall be entitled to recover all costs including reasonable attorney's fees. I grant my permission to Prime Dental staff to call me to discuss matters related to this form. I have read to the above conditions and agree to their content.

I certify the information on the Patient Information Form is true and correct to the best of my knowledge. I will notify Prime Dental of any changes in my health status or any changes in the above information. I authorize routine dental diagnostic procedures. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and pre-medications considered necessary or advisable by the doctor for my comfort and well-being.

Signature of Patient/Guardian: _____Date: _____/_____/_____