---Patient Information---

_____

Preferred Name or Nickname

_____

Martial Status

Married Single Child Other

Please circle current status

Telephone confirmations are made a week before, and the day before your scheduled appointment. A verbal confirmation from you, the patient, is required. Thank you for your cooperation. *Please list your phone numbers below, so that we may contact you, in order to confirm your future appointments.*

(_____)_____-_____Home/Cell/Work *Please circle*

(_____)_____-_____Home/Cell/Work *Please circle*

(_____)_____-_____Home/Cell/Work *Please circle*

(_____)_____-_____Fax

Which is the best contact number to reach you at, in order to confirm future appointments?

(_____)_____-_____Home/Cell/Work *Please circle*

Whom may we thank for this referral?

Name:_____

Relationship to Patient:_____

Address:_____

Person responsible for account (if other than patient):

Name:_____ Relationship to Patient:_____

Address:_____

Phone Number:_____

Employer:_____ Since:_____

Social Security Number:_____

Payment will be made by: __Check __Cash __Credit Card

Payment and General Consent for
Radiographs, Study Models, and Photographs

I understand that I am responsible for my account, regardless of any insurance coverage that I may or may not have. I also understand that any insurance I may have is an agreement only between me and that insurance company, not with Dr. Bill Hanna, D.D.S. I understand that payment is due at the time of service. Therefore, I understand that I am responsible for the estimated patient portion of my balance at the time of service. I understand that any estimated patient portion on my treatment plan is only an estimate. Therefore, I understand that I am responsible for the total balance of any work done, whether or not insurance pays the total balance of its estimated portion. I also understand that the right to accept assignment of insurance benefits is solely at the discretion of Dr. Bill Hanna, D.D.S., and may be declined at any time, at which prompt payment for the remaining balance is required by me, the patient.

I understand that if I do not have dental insurance, that I am responsible for my balance in full, at the time of service.

I give permission for my dentist, Dr. Bill Hanna, D.D.S., his clinical team and staff to take any necessary radiographs, study models, and photographs in order to make a complete diagnosis of my dental needs. I also give permission for Dr. Bill Hanna, D.D.S. and his dental team to use my radiographs, study models, and/or photograph for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Patient's/Legal Guardian's Signature *Date*

(*I have read, agree to, and understand the statements above.*)

Do you have dental insurance?
Yes / No
If yes, please fill out the Insurance Information section below.

-----INSURANCE INFORMATION-----

Name of Primary Insurance Company_____

Address_____

Phone Number_____

Group/Plan Number_____

Subscriber's Name_____ Subscriber's Birthday_____

Subscriber's Employer Name and Address_____

Subscriber's Social Security Number_____

Subscriber's Relationship to Patient_____

----------ASSIGNMENT AND RELEASE----------

I, the undersigned, certify that I (or my dependent) have insurance coverage with

_____
(Name of Insurance Company)
and assign directly to Dr. Bill Hanna, D.D.S. otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature *Relationship to Patient* *Date*

Do you have any additional (secondary) insurance?
Yes / No
If yes, please fill out secondary insurance form below.

-----INSURANCE INFORMATION-----

Name of Secondary Insurance Company_____

Address_____

Phone Number_____

Group/Plan Number_____

Subscriber's Name_____ Subscriber's Birthday_____

Subscriber's Employer Name and Address_____

Subscriber's Social Security Number_____

Subscriber's Relationship to Patient_____

----------ASSIGNMENT AND RELEASE----------

I, the undersigned, certify that I (or my dependent) have insurance coverage with

_____

(Name of Insurance Company)

and assign directly to Dr. Bill Hanna, D.D.S. otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature *Relationship to Patient* *Date*

_____

Bill Hanna, DDS

1124 S. Lake

Fort Worth, TX 76104