



Glenn A. Boyles, D.D.S., M.S.

Patient Information (Confidential)

Date _____

Name _____ Birth date _____ Home phone _____

Address _____ City _____ State _____ Zip _____

Please check Minor Single Married Divorced Widowed Separated

If student, name of school/college _____ Full time Part time

Patient's or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Birth date _____

Address _____ Home phone _____

Employer _____ Work phone _____

Is this person currently a patient in our office? Yes No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth date _____ Social Security # _____ Date employed _____

Name of employer _____ Union or Local # _____ Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Co. address _____ City _____ State ____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ___ Yes ___ No If Yes, Complete the Following

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security # _____ Date employed _____

Name of employer _____ Union or Local # _____ Work phone _____

Address of employer _____ City _____ State ____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. address _____ City _____ State ____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Consent:

I consent to the diagnostic procedures and treatment deemed necessary by the orthodontist. I consent to the orthodontist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment.

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the orthodontist or orthodontic group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I attest to the accuracy of the information on this page.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Welcome to Boyles Orthodontics!