THANE B. ANDERSON DDS
Dentistry For Today's Family

1520 VERNON STREET, STOUGHTON WI 53589

WELCOME

Date: ____________________________________

Patient's Name: ____ Date of Birth: _________________ ☐ Male ☐ Female
Last First Initial

If Child: Parent's Name: _______________________________________

How do you wish to be addressed: ______________________________

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence - Street: ____

City: ________________________ State: _______ Zip: ______________

Business Address: ____

Telephone: Res.__________________ Bus.___________________________

Fax: ___________________________ Cell: __________________________

Email: ____

Patient/Parent Employer: ____

Present Position: ____

How long held: ____

Spouse/Parent Name: ____

Spouse Employer: ____

How long held: ____

Who is responsible for this account: ______________________________

Driver's License #: ____

Purpose of Call: ____

Other family members in this practice: ____________________________

____

Patient/parent Social Sec. No.: _________________________________

Spouse/parent Social Sec. No.: __________________________________

Someone to notify in case of emergency (not living with you):____________

____

Dental Insurance 1st Coverage

Employee Name: ____________________ Date of Birth: ___________

Employer Name: ________________________ Yrs.: _______________

Name of Ins. Co.: ____

Claims Address: ____

____

Telephone: ____

Group or Policy #: ____

Soc. Sec. or ID #: ____

Dental Insurance 2nd Coverage

Employee Name: ____________________ Date of Birth: ___________

Employer Name: ________________________ Yrs.: _______________

Name of Ins. Co.: ____

Claims Address: ____

____

Telephone: ____

Group or Policy #: ____

Soc. Sec. or ID #: ____

Whom may we thank for this referral: ______________________

Method of Payment: Insurance ☐ Cash ☐ Credit Card ☐

Consent:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist'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.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care: ____
My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the practice 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 agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I understand that a 1-1/2% late charge (18% APR) may be added to my account for all balances due for 60 days or more. If required, I also understand a check of my credit history may be made.

I attest to the accuracy of information on this page.

Patient's or Guardian's Signature: ____ Date: ___________________________