Hanover Road Dental Health

John N. Munsey, D.M.D Maura H. Sanders, D.M.D

Thank you for selecting our dental healthcare team! We will strive to provide you with the best Dental care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Mr.____ Mrs._____ Ms._____ Dr._____ Prof._____ Rev_____ Nickname: _____

Patients Name: Last_____ First_____ Middle Initial_____

SSN:_____ Date of Birth: _____ Age: _____ Sex: M / F

□ Minor □ Married □ Single □ Divorced □ Widowed □ Separated □ Other _____

Physical Address: _____ _____ _____
Street/Apt# City State/Zip Code

Mailing Address: _____ _____ _____
St/Apt#/P.O. Box City State/Zip Code

Home Phone:_____ Work:_____ Cell:_____

Email address:_____ Previous Dentist:_____

Who may we thank for referring you to our office? _____

Please complete below if Patient is a Dependant

Parent/Guardian _____ Parent/Guardian_____

Address _____ Address (if different) _____

_____ _____

Home/Cell/Work:_____ Home/Cell/Work:_____

Email _____ Email _____

Emergency Contact Information

Name _____ Relationship _____ Phone # _____

Dental Insurance Information (Primary)

Policy Holder _____ Relationship to Patient _____

Employer_____ Business Phone _____

Insurance company _____ Date of Birth _____

Address _____ Group # _____

Phone # _____ Sub ID/SSN # _____

Dental Insurance Information (Secondary)

Policy Holder _____ Relationship to Patient _____

Employer_____ Business Phone _____

Insurance company _____ Date of Birth _____

Address _____ Group # _____

Phone # _____ Sub ID/SSN# _____

Release:

I authorize Hanover Road Dental Health to perform diagnostic procedures (including x-rays) and treatment as may be necessary for proper dental care.

I authorize release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize the release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

I attest to the accuracy of the information on this page.

I authorize payment of insurance benefits to Hanover Road Dental Health. Payment is expected time of service. Balances unpaid after 60 days are subject to a finance charge of 1.5% per month or 18% per annum.

_____ _____

Patient or Guardian's Signature Date