# Family Dental Center of Caledonia, L.L.C.

120 W. Main St. • Caledonia, MN 55921-1109 (507)725-5254

## Welcome to our Practice

**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **SS#:** ___-__-____ **Prev. Visit:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

## Responsible Party Information:

**This only needs to be completed if the insurance subscriber is someone other than the patient, or your are the parent/guardian of the patient.**

**The following is for:** ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

**Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **SS#:** ___-__-____ **DL#:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

## Primary Dental Insurance:

**Name of Insured:** _____ _____ ___
Last First MI

**Insured's Birth Date:** _____ **ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____

Address 1 Address 2

_____ _____ _____-_____

City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____

Address 1 Address 2

_____ _____ _____-_____

City State Zip Code

**Insurance Company Phone Number:**

_____

_____

**Insurance Authorization:**

☐ **By checking this box,**
**I authorize my insurance company to pay the dentist all insurance benefits rendered.**
**I authorize the use of this electronic signature on all insurance submissions.**
**I authorize the dentist to release all information necessary to secure the payment of benefits.**
**I understand that I am financially responsible for all charges whether or not paid by insurance.**

**Name and Relationship to Patient:**

_____

_____

Signature _____ **Date** _____

**Response Date:** _____