



J SCOTT MAHANEY, DDS

◆ FAMILY & COSMETIC DENTISTRY

Date: ____/____/____

Patient Information

Social Security# ____-____-____

Patient name: _____ Gender ____ Birthdate ____/____/____ Age: ____
Last, First Preferred Name

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____ Work: _____ (ext) _____

Email Address: _____

If you are a new patient, how were you referred to our office?

____ Phone Book ____ Website ____ Newspaper ____ Relative ____ Friend

Name of person who referred you to our office: _____

Insurance Information & Authorization

We welcome the opportunity to assist you with your dental insurance.

If we are filing your claim for you, it is important that you understand we will be estimating your portion according to the general information given to us by your insurance company. This portion is due at the time of service.

Once a claim is filled, actual benefits are determined by your insurance carrier. If there is a remaining balance on your account after insurance completes payment, you are financially responsible for that balance. That balance will be due immediately upon receiving notification from our office.

Please Check:

- ☐ I authorize payment of benefits directly to the provider.
- ☐ I authorize the release of all necessary information to the insurance carrier and their representatives.
- ☐ I have read this form and agree to be financially responsible for any balance remaining on my account.

Consent For Services

Please Check:

- ☐ I authorize Dr. Mahaney to take radiographs, study models, photographs and/or any other diagnostic aids deemed appropriate. I also authorize Dr. Mahaney to prescribe any and all forms of medication and perform any treatment that may be indicated and agreed upon.
- ☐ I understand that photographs may be used as a record of my care and/or utilized for case studies in the office or on the office website. At no time will your personal information or identity be disclosed.
- ☐ I am aware that Dr. Mahaney follows the protocol of HIPAA's notice of privacy laws and I have been offered a copy of these laws.
- ☐ I agree to be financially responsible for any balance on my account.

Signature of patient, parent or guardian

Relationship to Patient

Date