

Mountain West Family Dentistry
9299 S. Broadway, Suite 200
Highlands Ranch, CO 80129

Patient Information for Mountain West Family Dentistry

Patient Name: _____

Gender: ___ Male ___ Female Family Status: ___ Married ___ Single ___ Child ___ Other

Birthdate: _____ SS# _____

E-mail Address: _____

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

Address: _____

City

State

Zip Code

Whom may we thank for referring you to our practice?

___ Former Patient ___ Insurance list ___ Referral from another office

___ Friend ___ Location ___ Facebook ___ Internet

Name of person or source referring you to our practice: _____

Responsible Party Information (mark same for this section if information is above)

Name: _____

Birth date: _____ Email address _____

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

Address: _____

City

State

Zip Code

Employment Information

Information for: ___ Patient ___ Person responsible for payment

Employer name: _____

Address: _____

City

State

Zip Code

Employer Phone Number:

(____) _____

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Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and/or alternative benefits given, you will be responsible for paying the full balance amount remaining on the account at that time. Our office will make an attempt to appeal any claim that we feel is incorrect. We will provide the necessary documentation your insurance company requests to settle the claim. If your insurance company has not made payment within 30 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____

Insured's Birth date: _____ ID #: _____ Group # _____

Subscriber # _____ Insured SS#: _____

Patient's relationship to insured: ___Self ___Spouse ___Child ___Other

Insurance Plan Name: _____

Insurance Address: _____

_____ City State Zip Code

Insurance Phone Number: (____) _____

Secondary Dental Insurance:

Name of Insured: _____

Insured's Birth date: _____ ID #: _____ Group # _____

Subscriber # _____ Insured SS#: _____

Insured's Address: _____

_____ City State Zip Code

Insured's Employer's Name: _____

Employer Address: _____

Patient's relationship to insured: ___Self ___Spouse ___Child ___Other

Insurance Plan Name: _____

Insurance Address: _____

_____ City State Zip Code

Insurance Phone Number: (____) _____