DAVID J BADDOUR DDS
ASHLAND CHARDON PATASKALA
DENTAL ARTS

Welcome!

Dr. Baddour and Associates would like to thank you for the opportunity to care for you.

Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ Social Security Number _____ Marital Status _____ Spouse's Name _____

Home Phone _____ Cell Phone _____ Work Phone _____ Email _____

Student Status (if applicable) __ Full Time __ Part Time School Name _____

I would like to receive appointment reminders by: __Email __ Text

Insurance Information

Subscriber's Name _____ Relation to patient _____ Subscriber's Social Security Number _____ Subscriber's Birthdate _____

Insurance Company _____ Employer _____ Identification Number _____ Group # _____

Address to send Claims _____ Customer Service Number _____

Please initial below:

_____ I understand that I am fully responsible for knowing my insurance benefits and any dental claims submitted to my insurance company by Dr. David Baddour will be a courtesy.

_____ I understand that any pretreatment cost quoted by an employee of Dr. David Baddour is an estimate.

_____ I understand that a predetermination quoted by my insurance company is not a guarantee of payment.

_____ I understand that I will be charged a $50 missed appointment fee if I cancel within 24 hours.

_____With any appointment canceled within 24 hours notice, I understand that my account may be subject to closure or I may only be able to receive appointments available on the date of scheduling, to be determined by the office manager.

I certify that the information provided is accurate to the best of my knowledge. I also certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr David Baddour, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all professional services rendered, whether or not paid by the insurance. I also acknowledge that if my account is sent to an attorney or collection agency, I am responsible for any and all of these fees charged to my account. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date _____