Hanover Road Dental Health

Terry W. Bradigan, D.D.S   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.

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Patient or Guardian's Signature Date