DAYTON DENTAL

Cosmetic, Family & General Dentistry - Kelly R. Monroe, DDS

2020 S. Parker Road - Suite F - Denver, CO 80231 - (303) 752-2777 (P) - (303) 752-2780 (F)

Personal Information

First Name________________________Last Name____________________________Middle Initial________
Preferred Name____________________Address____
City, State, Zip____
Home Phone____________________Work Phone______________________Cell Phone________________
Male ☐Female ☐Minor ☐Single ☐Married ☐Domestic Partner
Birth Date____________________________Social Security #____________________________________
Employer___________________________________Occupation__________________________________
E-mail Address____
How do you prefer to be contacted? ☐E-mail ☐Phone ☐Text Message
Emergency Contact____________________________________Phone_____________________________

Responsible Party

Who is responsible for the account? ____
Name____
Relationship to Patient_______________Birth Date_______________Driver's License #_________________
Social Security #_________________________________E-mail Address______________________________
Address____
City,State,Zip____
Employer___________________________________ Occupation______________________________
Method of Payment ☐Cash ☐Check ☐Credit Card

Primary Insurance Information

Name of Insured _____________________________________Relationship to Patient___________________
Insured's Birth Date___________________Insured's Social Security #______________________________
Employer_________________________Date Employed_____________Occupation__________________
Insurance Company____
Claims/Insurance Company
Address____
City, State, Zip____
Group #________________________Employee ID #_______________________________________
Secondary Insurance: Insurance Company____
Claims/Insurance Company Address_____________________________City, State, Zip________________
Group #________________________Employee ID #_______________________________________

Consent:

I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance**. I also assign all benefits to Name of Provider. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this provider and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular devices. I further understand that if I don't cancel my appointment more 24 hours before the appointment I will be responsible for a cancellation fee of $45.00/hour allotted for my appointment.

Responsible Party's
Signature_____________________________________Date____________________