

John F. Conaghan, D.D.S. & John T. Corrigan, D.D.S.
Family & Cosmetic Dentistry

Patient Information:

Today's Date: _____ Patient Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

E-Mail: _____ Cell Phone: _____

Sex: _____ SSN: _____ Date of Birth: _____ Marital Status: _____

Who may we thank for referring you? _____

Employer: _____

Employer Address: _____

Insurance Information:

Who is responsible for this account?: _____

Relationship to patient: _____

Name of Insurance Company: _____ Group # _____

Subscriber's Name: _____ DOB: _____

Subscriber's SSN or Insurance Company assigned ID: _____

Insurance Company Address: _____

Assignment & Release:

I certify that I, and/or my dependent(s) have insurance coverage with the above listed insurance company. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance claim documents and submissions. Dr. Conaghan and Dr. Corrigan and their staff may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that all insurance claims are filed on my behalf, and that unless other arrangements are made before treatment is started, all insurance benefits will be paid directly to the member or subscriber of my insurance plan in the form of a reimbursement check from the above listed insurance company.
