DES MOINES RIVER
DENTAL CARE
65 School St., Carlisle, IA 50047
515-989-3180

PATIENT INFORMATION

Patient Name: ______________________________

Date of Birth: ____/____/____ SS#: ______________________________

Patient Address: ______________________________ City: ______________ State: __________ Zip: __________

Employer: ______________________________

Who may we thank for referring you? ______________________________

Home Phone: ______________________________ Cell Phone: ______________________________

Work Phone: ______________________________ Email: ______________________________

Dental visits are confirmed by PHONE, TEXT MESSAGE, or EMAIL
Please let us know if you prefer not to receive appointment messages by text or email.

Who is your Medical Doctor / Pediatrician / Family Doctor? ______________________________

M.D.'s Phone: ______________________________

Pharmacy Name: ______________________________

INSURANCE INFORMATION

Insured's Employer: ______________________________ Insured's Insurance Carrier: ______________________________

Policy Holder: ______________________________ Date of Birth: ____/____/____ Effective Date: ____/____/____

Insurance ID# or SS#: ______________________________

Secondary Insurance Employer: ______________________________ Insured's Insurance Carrier: ______________________________

Policy Holder: ______________________________ Date of Birth: ____/____/____ Effective Date: ____/____/____

Insurance ID# or SS#: ______________________________

ASSIGNMENT AND RELEASE OF BENEFITS

I certify this information is true and correct to the best of my knowledge. Des Moines River Dental Care has my authorization to adhere to my consents outlined on this form.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.

Signed: ______________________________ Date: ______________________________

Des Moines River Dental Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(515)989-3180.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-(515)989-3180。

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