Gateway Dental Group

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1540 High Street, Suite 201 • Des Moines, IA 50309 (515)244-9565

PATIENT INFORMATION

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* _____* _____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____

Prev. Visit: _____

Email Address: _____

Phone: _____* _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____* _____
Address 1 Address 2

_____* _____* _____-_____*
City State Zip Code

How did you hear about Gateway Dental Group?

☐ Family member ☐ Friend ☐ Co-worker ☐ Dentist
☐ Physician ☐ Internet ☐ A team member in our office ☐ Other

Please provide an emergency contact name and number:

RESPONSIBLE FINANCIAL PARTY

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____

Email Address: _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Secondary Insurance

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____

Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

Address 1 Address 2

_____ _____ _____-____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

Address 1 Address 2

_____ _____ _____-____

City State Zip Code

Please confirm the statements below by checking each box that applies:

☐ I hereby authorize Gateway Dental Group to affix my name to any and all dental insurance claims or documents as related to any and all dental health benefits due to me.

☐ I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or Gateway Dental Group has a contractual agreement with my dental benefit plan prohibiting all or a portion of such charges.

☐ To the extent permitted by law, I consent to your use and disclosure of my protected health information in connection with dental insurance claims submitted by Gateway Dental Group.

☐ I hereby authorize and direct payment of dental benefits directly to Gateway Dental Group, which are otherwise payable to me.

☐ I authorize the use of my electronic signature on all dental insurance claim submissions.

Response Date: _____