David R. Stebbins, D.M.D. LLC 148 East Avenue, Suite 3J, Norwalk, CT 06851 203.866.0415 F 203-354-9561

Getting Acquainted

Patient Information

Please provide copy of patient's or guarantor's driver's license

Patient Name______________________________ Today's Date______________

Address______________________________ Apt__________

City______________________ State____________ Zip Code__________

Social Security #_______-______-_______ Date of Birth______________________

Employer ______________________ Occupation______________________

Whom may we thank for referring you?______________________________

Contact Information

Home (_____)________________ Work(_____)_______________ ext.________

Cell (_____)________________ E-mail______________________________

****We confirm appointments electronically. Do you prefer: text email both (please circle)

Emergency Contact Information

Name______________________________ Relationship________________

Home (____)____________ Work (____)____________ Cell (____)____________

Primary Insurance

Please provide copy of insurance card

Subscriber's Name______________________________ Date of Birth____________

Social Security #______-_____-______ Insurance ID#______________________

Insurance Company______________________ Group#________________

Employer______________________________ Relationship to Patient__________

Secondary Insurance

Please provide copy of insurance card

Subscriber's Name______________________________ Date of Birth____________

Social Security #______-_____-______ Insurance ID#______________________

Insurance Company______________________ Group#________________

Employer______________________________ Relationship to Patient__________

Account Guarantor & Insurance Assignment & Release

I am responsible for all charges for services rendered, regardless of insurance coverage, if any. I give permission to send and receive correspondence, including dental records and financial records, electronically. In the event of default, I am responsible for all collections costs, court costs, and attorney fees required to collect the account balance. (Must sign if age 18 or older.)
For patients with insurance: I understand that my insurance policy is a contract between me and my insurance company and that I am responsible for all charges for services rendered, regardless of insurance coverage. I authorize my insurance company to pay to David R. Stebbins, D.M.D. LLC all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the Dr. David R. Stebbins to release all information necessary to secure the payment of benefits. I agree to pay all deductibles and co-pays at the time of service.

Signature ______________________________ Date______________

Print Name ______________________________ Relationship to Patient______________

For your convenience, our office accepts cash, check, VISA, MC, AMEX, Discover, and Care Credit.