Welcome to Our Practice This confidential information will help us prepare for your visit.

NAME _____
Mr. Mrs. Ms Rev. Dr.

I prefer to be addressed as _____

Birth date ___/___/___ SS# _____-____-_____

Address _____ PO Box _____

_____ Zip _____

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Home # _____ Work # _____ Ext ____

E-mail address_____

Cell #_____

Employer _____

Address _____

Occupation _____ There for ___ yrs

Where and when is best to reach you? _____

Who referred you to our office? _____

Other family members seen by us _____

Last dental visit _____

Seen by Dr. _____ for _____

Spouse's Name _____

Birth date ___/___/___ Work # _____

Employer _____

Address _____

Occupation _____ There for ____yrs

Account Information
Name on Account _____
❑Self ❑Spouse ❑Other
❑ I may wish to establish a credit history with your office for personalized financial agreements. I authorize a credit history report.

Why have you made this dental appointment at this time?

_____

Why did you leave the office of your previous dentist?

_____

Dental Insurance Information

PRIMARY
Insured Name _____

Insured Birthdate ___/___/___ SS# _____-____-_____

Employer _____

Insurance Company _____ Group # _____

Insurance Address_____
_____

SECONDARY
Insured Name _____

Insured Birthdate ___/___/___ SS# _____-____-_____

Employer _____

Insurance Company _____ Group # _____

Insurance Address_____
_____

As a courtesy to our valued patients, we will file claims for your insurance on your behalf. The responsibility of the insurance company is to you and it is your responsibility to see that you are reimbursed properly. Fees for services provided to insured patients are our normal fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company. The percentage of the fee paid may therefore be different than the percentage you were told by your insurance company or than the percentage listed in your benefit booklet. James F. Otten, D.D.S. does not participate with any insurance companies in the fee schedules they have developed. In deciding whom he should participate with the doctor has selected YOU. We respect the trust you place in us and believe that our relationship is negatively affected when third party interests are mandated. We will do our very best to see that you receive all of the benefits due you.

PLEASE TURN OVER AND COMPLETE THE ADDITIONAL INFORMATION ON BACK

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I understand that dentistry is an inexact science and authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written and signed financial agreements have been made. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

Signed_____**Date**_____

Thank you for filling this form out completely. If you have questions regarding this form or any aspect of our dental practice please call.

James F. Otten, D.D.S.
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Lawrence, KS 66044

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