Affordable Dental Care-Tacoma
3402 S. 18th Street
Tacoma, WA 98405
(253) 471-2655

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone # ( ) _____ Cell Phone # ( ) _____ Email _____

Employer _____ Employer Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone ( ) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone ( ) _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Alternate ID # _____

Insurance Company _____ Group # _____

ADDITIONAL DENTAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Alternate ID# _____

Insurance Company _____ Group # _____

CONSENT OF FINANCIAL RESPONSIBILITY

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Affordable Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of any information necessary concerning my (or my dependent's) health care to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, authorize the dentist to perform diagnostic procedures and treatment as may be necessary for the delivery of proper dental care. I authorize the release of any information concerning my (or my dependent's) health care, for advice and treatment to another dentist, or another health care professional and their staff. I authorize the release of information concerning my (or my dependent's) health care to this additional person or organization.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

We require a minimum of 24 hours notice for cancellations and rescheduling. Subject to a $50.00 charge without a 24 hour advance notice.