Confidential Financial Information

TODAY'S DATE: ____/____/____

Charles E. Montoure, DDS, MS
Mark H. Hanson, DDS, MS

ADULT PATIENT INFORMATION

PATIENT: *First* *Middle* *Last*			SPOUSE:	
ADDRESS:			AGE:	SEX: ☐ M ☐ F
CITY:	STATE:	ZIP:	HOME PHONE:	
MARITAL STATUS: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single		☐ Own ☐ Rent	YEARS AT THIS ADDRESS:	

Montoure & Hanson Orthodontics offers interest-free payment options based on credit worthiness. In order to set up your account at our office, please fill out the following information in its entirety. Your Social Security Number may be needed to obtain credit history, or for filing a claim with your insurance, and will not be disclosed for any other purpose. Please initial that you have read and understand this information. INITIAL: _____

PATIENT INFORMATION			SPOUSE INFORMATION	
SOCIAL SECURITY #:	DATE OF BIRTH: / /		SOCIAL SECURITY #:	DATE OF BIRTH: / /
EMPLOYER:			EMPLOYER:	
POSITION (IF SELF EMPLOYED, LIST FIELD):		YEARS:	POSITION (IF SELF EMPLOYED, LIST FIELD):	YEARS:
WORK PHONE:	CELL PHONE:		WORK PHONE:	CELL PHONE:
EMAIL ADDRESS:			EMAIL ADDRESS:	

Montoure & Hanson Orthodontics will submit insurance claims on your behalf. Please bring your current dental insurance card(s) with you to your exam and fill out the following information in its entirety. We will verify your orthodontic coverage and provide you with an estimate for treatment based on this information.

PATIENT DENTAL INSURANCE			SPOUSE DENTAL INSURANCE		
DENTAL CARRIER:			DENTAL CARRIER:		
☐ Primary ☐ Secondary ☐ No Dental Insurance			☐ Primary ☐ Secondary ☐ No Dental Insurance		
MEMBER#:			MEMBER#:		
GROUP#:			GROUP#:		
INSURANCE CO. ADDRESS:			INSURANCE CO. ADDRESS:		
CITY:	STATE:	ZIP:	CITY:	STATE:	ZIP:
INSURANCE CO. PHONE:			INSURANCE CO. PHONE:		
I hereby authorize payment directly to Montoure & Hanson Orthodontics. _____ *Signature of Insured Person*			I hereby authorize payment directly to Montoure & Hanson Orthodontics. _____ *Signature of Insured Person*		

I certify the information on this form is true to the best of my knowledge. I accept responsibility for the dental charges incurred. I understand my dental insurance provider may pay less than the actual bill for services and I am ultimately responsible for any balances due. I understand that I am responsible for any late fees, missed appointments and/or collection fees incurred. I also understand that where appropriate, credit bureau reports may be obtained. I acknowledge that Montoure & Hanson Orthodontics will provide me with a copy of their Privacy Practices upon request.

Signature of Patient: _____ Date: ____/____/____