Joseph P. Goodson, D.M.D., M.S.

Specialist in Orthodontics for Children Teens and Adults

WELCOME

Date _____

Patient's Name_____ Nickname_____

Address_____

City_____ Zip Code_____ E-mail address_____

Birthdate _____Home Phone _____ Cell Phone_____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____Work Phone _____Cell Phone_____

Address _____ Home Phone_____

How long at this address? _____ Relationship to Patient _____ *E-mail address*_____

Social Security Number_____ Birthdate _____

Employer _____ Occupation _____ No. Years Employed_____

Spouse's Name_____ Birthdate _____

I understand that a credit check may be required. _____
Initials

_____ _____
Signature of Financially Responsible Party Date

PRIMARY DENTAL INSURANCE

Insured's Name_____DOB:_____Member ID #_____

Dental Insurance Company _____ Employer _____Group #_____

Dental Insurance Co. Address _____Dental Insurance Co. Phone #_____

Do you have dual dental coverage? _____

Secondary Insured's Name_____ Social Security #_____

Secondary Insurance Company _____ Employer Group #_____
Secondary Insurance Co. Address _____Insurance Co.Phone #_____

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As a courtesy our office will file insurance claims, however any unpaid balances will be the patient's responsibility. It is important to recognize that your insurance policy is an agreement between you and your insurance company. Your benefit assignment does not take the place of your responsibility to pay for services received. If you have any questions regarding our payment policy, please consult our Treatment Coordinator. In cases of divorced parents, the parent bringing the child to the initial visit will be deemed responsible for payment. Our office will not become involved in custody disputes over which parent is the responsible billing party.

I have read the above and understand that I am responsible for all office charges. I authorize the release of any medical or dental information necessary to process insurance claims and request payment of benefits to the provider of services.

Signature of responsible party Date