Tim Loughran Dentistry
ADVANCED COSMETIC + FAMILY CARE

WELCOME TO TIM LOUGHRAN DENTISTRY – TELL US ABOUT YOURSELF

Name: _____ DL# _____
Last First M.I.

Preferred Name: _____ ☐ Male ☐ Female DOB: _____

Address: _____ City _____ State ____ ZIP _____

SSN: _____ E-mail Address: _____

Home phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married

How did you hear about our office? _____

Family members who are patients: _____

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Tim Loughran Dentistry 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 doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____