Mountain West Family Dentistry
9299 S. Broadway, Suite 200
Highlands Ranch, CO 80129

Patient Information for Mountain West Family Dentistry

Patient Name: _____

Gender: ____Male _____Female Family Status: ___Married ___Single ___Child ___Other
Birthdate: _____ SS#_____
E-mail Address: _____
Phone: (___)_____ (____)_____ (____)_____
Home Cell Work
Address: _____
_____
City State Zip Code

Whom may we thank for referring you to our practice?

_____Former Patient _____Insurance list _____Referral from another office

_____Friend _____Location _____Facebook _____Internet

Name of person or source referring you to our practice: _____

Responsible Party Information (mark same for this section if information is above)
Name: _____
Birth date: _____ Email address _____
Phone: (___)_____(___)_____(___)_____
Home Cell Work
Address: _____
_____
City State Zip Code

Employment Information
Information for: _____Patient _____Person responsible for payment
Employer name: _____
Address: _____
_____
City State Zip Code
Employer Phone Number:
(_____)_____

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Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and/or alternative benefits given, you will be responsible for paying the full balance amount remaining on the account at that time. Our office will make an attempt to appeal any claim that we feel is incorrect. We will provide the necessary documentation your insurance company requests to settle the claim. If your insurance company has not made payment within 30 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____

Insured's Birth date: _____ ID #: _____ Group # _____

Subscriber #_____Insured SS#:_____

Patient's relationship to insured: ____Self ____Spouse ____Child ____Other

Insurance Plan Name: _____

Insurance Address: _____

_____

City State Zip Code

Insurance Phone Number: (___)_____

Secondary Dental Insurance:

Name of Insured: _____

Insured's Birth date: _____ ID #: _____ Group # _____

Subscriber #_____Insured SS#:_____

Insured's Address: _____

_____

City State Zip Code

Insured's Employer's Name: _____

Employer Address: _____

Patient's relationship to insured: ____Self ____Spouse ____Child ____Other

Insurance Plan Name: _____

Insurance Address: _____

_____

City State Zip Code

Insurance Phone Number: (___)_____