

Welcome to the office of Dr. Steven E. Timm
GENERAL & PREVENTATIVE DENTISTRY

Patient Information

Male / Female Date of Birth ____ / ____ / ____
Patient Given Name _____ Nick Name _____ MI _____
Home Phone _____ Cell Phone _____ Work _____ EXT _____
Mailing Address _____ City / State / Zip _____
Street Address if PO Box used _____ Driver License # _____
Employer Name _____ Work Phone _____ How long _____
Who may we thank for referring you to our office, a friend/ family member/ Phone book? _____
Emergency Contact Name _____ Relationship _____ Phone # _____

Responsible party (if patient is a **minor**) Name: _____ Relationship _____
Address _____ City/State/Zip _____ Cell Phone _____
Parent Date of Birth ____ / ____ / ____ Employer _____ Work Phone _____

Primary Dental Insurance Information

Relationship to card holder Self/ Spouse / Child
(Subscriber) _____ Policy Holder Date of Birth ____ / ____ / ____ *Group* # _____
Policy Holder's Employer _____ Subscriber's social security #/ or ID # _____ - _____ - _____
Insurance CO. Name _____ INS. Co. Phone # (_____) _____
INS. CO. Address _____ City/State/Zip _____
Located on the back of your insurance card

Secondary Dental Insurance

Relationship to card holder Self/ Spouse / Child
Subscriber Name _____ Subscriber's Date of Birth ____ / ____ / ____ * Group* # _____
Employer _____ Work Phone # _____ Social Security # _____ - _____ - _____
Insurance Co. Name _____ INS. Co. Phone # (_____) _____

Please be sure to inform our business office of **any insurance changes. As a courtesy our office will follow through on all outstanding claims up to 90days from the date of service. Your assistance is appreciated to expedite the handling of your dental reimbursement plan.

Consent for Services

To the best of my knowledge all information provided is accurate & up to date. If ever there is a change in my health, I will inform the staff in the office of Dr. Steven Timm without fail. I authorize the release of records to the insurance company to secure payment of benefits to the office of Steven Timm, DMD. I authorize my insurance benefits to be paid directly to Dr. Steven Timm & I understand I am financially responsible, regardless of my insurance status, for all charges whether or not paid by insurance. I understand that my insurance may not pay 100% of various dental procedures and that my estimated patient payment is **due at the time of service**. Any unpaid balance over 60 days are subject to finance charges.

I hereby authorize the release of ALL records, including full mouth/ or panoramic film within the last 5 years, and/ or bitewing x-rays. Please send films to the office of Dr. Steven E. Timm, 361 NE Franklin Ave Bend, OR 97701.

Patient Signature

Date

Y/N _____