Emergency Contact Information

Patient Name:_____

Contact Person: _____ Relationship to Patient: _____

☐ Male ☐ Female

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Insurance Phone Number _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services & To Bill Insurance

My signature below indicates that:

- I consent and authorize Richard M. Yarbro, DDS and staff to provide my dental care to myself and/or to any minors under my care. I understand this could include various tests and exams, radiographic images, other diagnostic procedures, as well as various forms of dental treatment. I understand Dr. Yarbro is available to explain my treatment, alternative forms of treatment, and that I have the right to refuse treatment.
- I am aware that the doctor will explain to me certain inherent and potential risks in any treatment or procedure, and I consent to treatment by him or any of his staff that he assigns to my care.
- I consent to the administration of anesthesia, including local anesthesia and nitrous oxide analgesia, in connection to any dental procedures, and the use of such anesthetics as may be deemed advisable.
- I give permission for Richard M. Yarbro Family Dentistry, PS to bill my insurance company for covered services and to exchange information necessary to secure payment for these services. Such necessary information my include diagnosis, service dates, types of services, radiographic images, and other information related to treatment and services necessary to process claims.
- I understand if an insurance payment is made directly to me for any services provided by Richard M. Yarbro Family Dentistry, PS, I am responsible for immediately sending such payments to the provider that delivered the service.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party