Midtown Dental
BISMARCK

Welcome

Andrew J. Schmid, DDS
Kevin S. Bjork, DDS

ABOUT YOU

First Name _____ Last Name _____ MI _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____ Social Sec. # _____ - _____ - _____

DOB: _____/_____/_____ ☐ Male ☐ Female Cell #: ( ) _____ Home #: ( ) _____ Work #: ( ) _____

Were you referred to us? ☐ Yes ☐ No If yes, who referred you? _____ Previous Dentist: _____

Employer Name: _____ Occupation: _____ Length of employment: _____

Preferred Communication: ☐ Text ☐ Email ☐ Phone call Email Address: _____

Emergency Contact: _____ Relation: _____ Contact #: ( ) _____

DENTAL INSURANCE INFORMATION

☐ I do **not** have dental insurance

Primary

Insurance Co. Name: _____ Group #: _____ Member ID#: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Insured's Name/Policy holder: _____ Insured's DOB: _____/_____/_____ Relation: _____

Insured's Employer: _____ Insured's SSN: _____ - _____ - _____

Secondary

Insurance Co. Name: _____ Group #: _____ Member ID#: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Insured's Name/Policy holder: _____ Insured's DOB: _____/_____/_____ Relation: _____

Insured's Employer: _____ Insured's SSN: _____ - _____ - _____

PAYMENT INFORMATION

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Midtown Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____ _____/_____/_____
Patient Signature Date