Marshall Dental, PLC
159 Lichfield Boulevard
Suite 107
Fredericksburg VA 22406-

www.marshalldentalva.com
(540)373-2273
marshalldentalva@gmail.com

# Welcome to Marshall Dental

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

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# Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

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## Primary Dental Insurance:

Name of Insured: Last First MI

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

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Insurance Company Phone Number:

## Insurance Authorization:

By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

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Do you have Secondary Insurance? If No, Please do not fill out information below:

◯ Yes ◯ No

## Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

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

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insurance Company Phone Number:

_____

## Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

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## Consent For Treatment:

As the undersigned, I hereby authorize Marvin L. Marshall, Jr., D.D.S. (THE DOCTOR) and Marshall staff to, after thorough explanation, take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by THE DOCTOR to make a diagnosis of my or my dependent's dental needs. I also authorize THE DOCTOR to perform any and all forms of treatment, medication and therapy that may be indicated (after they are discussed with me) and futher authorize and consent that THE DOCTOR choose and employ such assistance as they deem fit. I also understand the use of anesthetic agents embodies a certain risk.

## Consent for information release and assignment:

I authorize "Release of Medical Information" for insurance purposes by THE DOCTOR. The required "Assignment of Benefits" is noted and I authorize payment directly to the doctor as lister for any treatment received by myself and/or any dependent's. I understand that PAYMENT IS DUE AT THE TIME OF SERVICE. I also understand I am responsible for all fees not covered by assignment of benefits, for any reason. I acknowledge if my claim is not paid within 60 days the full balance is MY RESPNSIBILITY.

## Consent for fee associated with non-payment:

In the event of non-payment and/or a returned check, I agree to pay any and all costs of cellections including 1.5% interest per month on any unpaid balance, any and all court costs, atttorney fees allowed by law and/or a Returned Check Fee of $50.00. I understand that if necessary an outside agency will be enlisted to recover any fees owed to Marshall Dental and as such there may be an adverse affect upon my credit rating.

☐ By checking this box, I acknowldge that I have read this statement and agree to the contents.

Signature: _____ Date: _____

Response Date: _____