



Richard F. Davis, D.M.D. • Stefan Speck, D.M.D.  
306 Limestone Rd., Oxford, PA 19363 • 610.932.9580

## Welcome to Oxford Family Dentistry.

### Please tell us how you found out about us:

Advertisement  Yellow pages  Referral  Mailing  Internet  Other \_\_\_\_\_

### If you were referred by one of our patients, please let us know so we can thank them for their vote of confidence.

Referred By: \_\_\_\_\_

### PATIENT INFORMATION

Patient's name \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Do you have dental insurance?  Yes  No

Subscriber's name \_\_\_\_\_ Employer's name \_\_\_\_\_

Subscriber's DOB \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's name \_\_\_\_\_ Employer's name \_\_\_\_\_

Subscriber's DOB \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

### A beautiful smile is a worthwhile investment, would you be interested in a free cosmetic consultation to find out how you can improve the appearance of your teeth? Yes No

### CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it's my responsibility to inform my doctor if I or my minor child ever has a change in health or medication.

### MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of \_\_\_\_\_ And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present when service is rendered.

### INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) are covered by insurance with \_\_\_\_\_ and assign directly to Dr. Davis, Dr. Speck and/or Dr Niemoeller all insurance benefits. If any otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

### FINANCIAL AGREEMENT

I acknowledge the payment is due at time of treatment unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor child. I accept full responsibility for all charges for services or items provided to me or the patient. I understand filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature of patient, parent, guardian, or personal representative \_\_\_\_\_

Print name of patient, parent, guardian, or personal representative \_\_\_\_\_

Relationship to patient \_\_\_\_\_ DATE \_\_\_\_\_