GAITHERSBURG DENTAL ASSOCIATES
8 Russell Avenue, Suite 104
Gaithersburg, MD 20877

Patient Information and Insurance Form

Full Name:			Date:
Street Address:			
City:	State:		Zip:
Home Phone:		Work Phone:	
Mobile Phone:		Email Address:	
Date of Birth:	Age:		Sex: o M o F
Marital Status: o M o S o D o W		Maiden name:	
SS #:		Employer:	
Physician's Name:		Occupation:	
Physician's Phone #:		How did you hear about us?	
Spouse/Guardian Name:		Spouse/Guardian Phone #:	

Others in the family	Relationship	SS#	Date of Birth
	Spouse		
	Child		
	Child		
	Child		
	Child		

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Company:		Insurance Company:	
Insurance Company Phone:		Insurance Company Phone:	
Policy Holder Name:		Policy Holder Name:	
Policy Holder DOB:		Policy Holder DOB:	
Policy Holder SS#:		Policy Holder SS#:	
Policy Group #:		Policy Group #:	
Policy ID #:		Policy ID #:	
Plan Name:		Plan Name:	
Effective Date:	Exp. Date:	Effective Date:	Exp. Date:

I authorize Gaithersburg Dental Associates to release any information relating to care for my dependents and myself to insurance company(s) or third party carriers and request payment to be made directly to the Gaithersburg Dental Associates. Filing insurance claims is a courtesy provided to our patients by the Gaithersburg Dental Associates. I understand that I am fully responsible for any fees that are not covered/rejected by my insurance company for the services provided to me and my dependents and I will pay them promptly and in full upon being notified. I further acknowledge and agree that for failure to pay any amounts I owe to Gaithersburg Dental Associates, my account may be turned over to a collection agency and I will be responsible for and will pay all collection agency costs, attorney's fees, and other costs and charges necessary for the collection of any amount not paid when due.

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Patient Signature or Guardian/Parent Signature ***Date***