Myers Family Dentistry

P: 541-679-4179
F: 541-679-1402
Joshua T. Myers, DDS
90 NW Glenhart Ave
Winston, OR 97496

Who may we thank for referring you?

_____

Patient Information

Name:_____ Birth Date: ___/___/___ SSN: _____
Employer / School_____ Employer/School Phone:_____
Mailing Address: _____ City: _____ State: ____ Zip: _____
Cell Phone: _____ Home Phone: _____
Email: _____
Emergency Contact: _____ Phone: _____

Person Responsible for Payment

Name: _____ Relationship to Patient: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ Cell Phone: _____

Primary Insurance Information

Name of Insured: _____
Relationship to Patient: _____
Birth Date of Subscriber: ___/___/____
SSN or Insurance ID: _____
Employer: _____

Secondary Insurance Information:

Name of Insured: _____
Relationship to patient: _____
Birth Date of Subscriber: ___/___/____
SSN or Insurance ID#: _____
Employer:_____

Myers Family Dentistry accepts payments by cash, check, credit card (Visa, MC, Discover, AMEX), Care Credit, and HSA's.

Please read and initial:

__ I understand that payment is due in full at time of services unless other arrangements have been made prior to treatment.
__ Myers Family Dentistry offers a 5% discount for all uninsured patients.

Patients with insurance, please read and initial:

__ I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Joshua T. Myers, DDS all insurance benefits, if any, otherwise payable directly to me for services rendered.
__ I understand that I am financially responsible for all charges, whether paid or not by insurance.
__ I understand that Myers Family Dentistry tries to determine insurance eligibility, benefits, maximums, coverage amounts, co-pays, but the ultimate responsibility to verify insurance benefits is with me. Insurance companies have great latitude to deny payment for whatever reason and even to retroactively reclaim money already paid out. I understand this and will pay for whatever my insurance company decides not to pay.
__ I authorize the use of my signature on all insurance submissions.
__ Myers Family Dentistry may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and understand the statements I have initialed above:

_____ _____ _____

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Patient/Guardian Signature | Printed name | Date