Smiles by design
DENTAL CARE

Dr. Fred J. Hermanson D.D.S, PA
7300 West 147th Street Ste. 302
Apple Valley, Minnesota 55124

Date _____/_____/_____ Referred by_____

Name:_____ DOB:_____/_____/_____

Address:_____ City:_____ State:____ Zip:_____

S.S.#_____ Male:___ Female:___ Marital Status (circle) S M W D Sep

Home Phone:_____ Cell:_____ e-mail:_____

Employer name and address:_____

Occupation: Person responsible for payment of account Self:___ Other:_____

Insurance Policy Holder's Information (If different than patient)

Name:_____ SS# ___/__/___ DOB _____/_____/_____

Address:_____

Home Phone:_____ Cell:_____ e-mail_____

Employer:_____ Work Phone:_____

Primary Insur:_____ Secondary:_____

Group #_____ Group# _____

ID #_____ ID#_____

Primary Policy Holder Name: _____ DOB_____

Secondary Policy Holders Name: _____ DOB_____

Emergency Contact:_____ Phone #:_____

I hereby request and authorize direct insurance payments to Fred J. Hermanson, D.D.S., PA. I understand that my insurance is an agreement between my insurance company and myself. I also understand that I am responsible for my balance regardless of insurance. I understand that if I have no insurance I will be asked to pay the cost of the services at the time I am seen. This form also authorizes the release of my dental information to other providers and/or insurance companies involved in my dental care.

_____ _____

Signature Date