**VILLAGE DENTISTRY**
**NICOLE VAN LE, DDS, LLC**
9105 E 56TH ST
INDIANAPOLIS, IN 46216

# Welcome

Patient's Name _____ Date of Birth_____ ☐ Male ☐ Female
If Child: Parent's Name_____
How do you wish to be addressed_____
Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐
Residence - Street_____
City_____State_____Zip_____
Business Address_____
Telephone: Res._____Bus. _____
Cell Phone_____
Email_____
Patient/Parent Employed By_____
Present Position_____
How Long Held_____
Spouse Employed By _____
Present Position_____
How Long Held_____
Who is Responsible for this account _____
Drivers License No._____
Purpose of Appointment _____
Other Family Members in this Practice _____
_____
Whom may we thank for your referral
Person_____ Internet ☐ Yellow Pages ☐
Other_____
Patient/Parent Social Security No._____
Spouse/Parent Social Security No._____

## 1st Dental Insurance

Employee Name _____
Employee's Date of Birth _____
Employee's Social Sec #_____
Name of Insurance Co. _____
Address _____
Insurance Telephone # _____
Program or Policy #_____
Social Security # _____
Union Local or Group_____

## 2nd Dental Insurance

Employee Name_____
Employer Name _____
Name of Insurance Co. _____
Address _____
_____
Insurance Telephone # _____
Program or Policy # _____
Social Security # _____
Union Local or Group _____

RELEASE: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor. I attest to the accuracy of the information on this page.

**PATIENT'S OR GUARDIAN'S SIGNATURE** _____

**DATE** _____