Michael O Vernon D.M.D. **Christopher M Moldovan D.M.D**

Augusta Dental Associates

1218 Augusta West Parkway
Augusta, GA 30909

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, appointments, or fees, please feel free to ask.

(Please Print) Today's Date: ___________________ Patients Date of Birth: _______________________

Name:

____

(Last) (First) (Preferred name) (Marital Status) (Spouse's Name)

Person responsible for payment of service rendered (guardian) ____

Residence Address: ____

(City) (State) (Zip)

Email Address: ____

Telephone: Home _______________Work _______________Cell ______________Social Security No: _____________________

Name of Business: ____Position:___________________________

Business Address: ____

(City) (State) (Zip)

Insurance

(PLEASE READ THOROUGHLY)

As a courtesy to you, we can take assignment of your dental insurance benefits. To accurately file your claims, please present your dental insurance card and complete the following information.

INFORMATION ABOUT THE PERSON WHO CARRIES THE DENTAL INSURANCE: Name: ______________________________

Social Security No.: ___________________________________ Date of Birth: ____

Dental Insurance Carrier: ____

Employer: ____Group Policy or Union No: __________________

Address to mail completed insurance claim: ____

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Your total balance charged and dental insurance is your financial responsibility, but we can help. If you wish for us to file your dental insurance, we must ask that you be prepared after each visit to pay the *ESTIMATED* amount that the insurance will not cover based on the information provided by your insurance company.

I hereby authorize the release to and the use by Michael O. Vernon, D.M.D., P.C. any dental or other information needed in processing the claims resulting from treatment rendered in this office.	I hereby authorize the payment of dental benefits directly to Michael O. Vernon, D.M.D., P.C. Christopher M. Moldovan, D.M.D., P.C.
____ Signed (patient) date	____ Signed (insured) date

PLEASE SEE OTHER SIDE