Todd P. Briscoe, D.D.S., P.C.

7833 Saint Joe Center Road
Fort Wayne, IN 46835
Ph: (260) 486-9950 Fax: (260) 485-1651
www.briscoedentistry.com

Patient Information

Please Use an Ink Pen

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ Title: _____ Sex: M/F Family Status: Spouse/Child/Other

Birth Date: ___/___/___ S.S.N. ___-___-___ Driver's License Number: _____ State: _____

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

E-Mail: _____ Is this checked daily? Y/N Home Phone: _____

Work Phone: (___) _____ Ext: _____ Best time to call: H: _____ W: _____

Cell Phone: (___) _____ Fax Number: (___) _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

How do you wish to have your appointments confirmed?
Please circle best options: Phone Call Text Message E-Mail

** How did you learn about our office? Location /Phone Book / Family / Friend / Web Site

Family or Friend's Name:_____ Address: _____

Responsible Party Information

(Person who is Responsible for Paying this Account)

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ Title: _____ Sex: M/F Marital Status: M/S/W/Guardian

Birth Date: ___/___/___ S.S.N.___-___-___ Driver's License Number: _____ State:_____

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

E-Mail: _____ Is this checked daily? Y/N Home Phone:_____

Work Phone: (___) _____ Ext: _____ Best time to call: H: _____ W: _____

Cell Phone: (___) _____ Fax Number: (___) _____

Employer: _____ Address: _____

Todd P. Briscoe, D.D.S., P.C.

City: _____ State: _____ Zip: _____

Spouse: _____ Birth Date: ___/___/___ S.S.N. ___-___-____

Financial Responsibility

I understand that I am responsible for all charges incurred for dental treatment received by myself or my family members. I understand, that where appropriate, credit bureau reports may be obtained.

Date: _____ Signature: _____ Updates: _____

Parental if patient is a minor

Insurance Information (Primary)

Employee: _____ ID Number: _____

Insurance Company: _____ Employer: _____

Claims Address: _____City: _____ State: _____ Zip: _____

Phone: _____Ext: _____ Contact Person: _____

Group Number: _____ Local Number: _____

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

_____ _____

Signature (Patient/Guardian) Date

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to the named dental entity. (Todd P. Briscoe, DDS, PC)

_____ _____

Signature (Employee/Subscriber) Date

Insurance Information (Secondary)

Employee: _____ ID Number: _____

Insurance Company: _____ Employer: _____

Claims Address: _____City: _____ State: _____ Zip: _____

Phone: _____Ext: _____ Contact Person: _____

Group Number: _____ Local Number: _____

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

_____ _____

Signature (Patient/Guardian) Date

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to the named dental entity. (Todd P. Briscoe, DDS, PC)

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Signature (Employee/Subscriber) Date

Todd P. Briscoe, D.D.S., P.C.