ISU Family Dentistry
1311 E. Central Dr., Meridian, ID 83642
Phone: 208.373.1855 / Fax: 208.373.1856

Patient Demographics

Patient Name: _____ **DOB:** _____

Address: _____ **Sex:** ☐ Male ☐ Female

_____ **Home Phone:** _____

Parent/Guardian: _____ **Cell Phone:** _____

Patient/Guardian S.S. #: _____ **Referred By:** _____

In case of an emergency, notify: _____ **Phone:** _____

Insurance Information

Insurance Provider(s): (Please check all that apply)

☐ Blue Cross ☐ Delta Dental ☐ Medicaid ☐ ☐

☐ ☐ ☐ ☐ ☐

☐ Private Pay ☐ Other: _____

Primary Subscriber ID: _____ **Group No.:** _____

Subscriber Name: _____ **Subscriber DOB:** _____

Secondary Subscriber ID: _____ **Group No.:** _____

Subscriber Name: _____ **DOB:** _____

Address: (if different from above) _____

Employer: _____

Payment is due at the time of service unless prior arrangements have been made.

Billing Policy

All co-pays will be due after insurance has been billed and processed. If you do not have insurance and have limited financial resources, you may be able to qualify for a discount. If you qualify for a fee reduction, a partial payment may be due at the time of service. Accounts past due more than 90 days will be sent to collections.

Consent

I authorize Idaho State University to release information necessary to process insurance claims on my behalf. I understand that I am responsible for all charges regardless of insurance and understand the billing policy as stated above. I authorize the use of this signature on all insurances submissions as well as the release of information necessary to secure the payment of benefits.

Signed By: _____ **Date:** _____

Parent/Guardian or Responsible Party