

**STANLEY HOMETOWN DENTISTRY**  
**JAMES GUNELSON, D.D.S.**

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
First Middle Last  
How do you wish to be addressed \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ MINOR \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMAIL \_\_\_\_\_ EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_  
Who may we thank for referring you to our practice? \_\_\_\_\_ Another Patient, Friend, Relative \_\_\_\_\_ Newspaper \_\_\_\_\_ Internet \_\_\_\_\_ Other \_\_\_\_\_

Name of person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**PRIMARY INSURANCE**

NAME OF INSURED \_\_\_\_\_  
RELATIONSHIP TO PATENT \_\_\_\_\_  
INSURED'S BIRTHDATE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
INSURANCE COMPANY \_\_\_\_\_  
INSURED'S ID # OR SS # \_\_\_\_\_  
GROUP # \_\_\_\_\_  
INSURANCE ADDRESS \_\_\_\_\_  
INSURANCE PHONE # \_\_\_\_\_

**SECONDARY INSURANCE**

NAME OF INSURED \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
INSURED'S BIRTHDATE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
INSURANCE COMPANY \_\_\_\_\_  
INSURED'S ID # OR SS# \_\_\_\_\_  
GROUP # \_\_\_\_\_  
INSURANCE ADDRESS \_\_\_\_\_  
INSURANCE PHONE # \_\_\_\_\_

- I authorize release of any information concerning my or my child's healthcare recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.
- I authorize payment of insurance benefits directly to Stanley Hometown Dentistry/James Gunelson DDS.
- I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.
- I agree to pay any applicable deductibles and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.
- I understand that I am responsible for and agree to pay the total fees for **mine** or **my child's** dental treatment.
- I agree to pay the total cost of dental services rendered on the date of service if **I** or **my child** does not have dental insurance benefits.

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_