garycashdds.com

Gary L. Cash DDS, P.C.

1500 WEST 38th STREET #48 | AUSTIN, TX 78731

512.451.7577

Thank you for choosing Dr. Gary Cash for your dental care!

Please take a moment to complete your information to help us ensure the quality of your care. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Confidential Patient Information

Patient Name _____ _____
Last First Middle Initial Preferred To Be Called

Gender: ☐ M ☐ F Family Status: ☐ Single ☐ Married ☐ Widowed ☐ _____

Address _____

_____
City State Zip Code

Birth Date _____ SS# _____ E-mail Address _____

Telephone _____ _____ _____
Home Mobile Fax

Employer _____ Telephone _____
Work Ext

Notify in case of emergency _____Contact Number_____
First Last

Whom may we thank for referring you to our practice? _____

Request for Confidential Communication

As my dental care provider, you may do the following with my permission **(must select at least one option)**:

	Yes	No
Contact me at home	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via e-mail	☐	☐
Leave messages on my home voicemail / answering machine	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave messages on my work voicemail / answering machine	☐	☐

Responsible Party Information

If someone other than the patient is responsible for this account, please provide that person's information below.

Guarantor's Name _____ Title _____
Last First Middle Initial Mr / Ms / Mrs / Etc

Address (if different from patient)_____

_____
City State Zip Code

Relationship to Patient _____ Birth Date _____ SS# _____

Telephone _____ _____ _____
Home Work Ext Mobile

Dental Insurance Information (*Please present your dental insurance card to the Front Desk.)*

Name of Subscriber _____
Last First Middle Initial

Subscriber's Date of Birth _____ Subscriber's SS # _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's Date of Birth _____

Insurance Company _____ Provider Customer Service # _____

Subscriber's ID# _____ Subscriber's Group ID # _____

Authorization

I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. I hereby certify that I have read and understand the previous information, and it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by radiographs, study models, photographs or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors and/or healthcare practitioners. I authorize the use of this signature on all insurance submissions. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policies.

Signature _____ Date _____