McKinney Family Dentistry

Dr. Chris McKinney
15525 Pomerado Road, Suite C-6
Poway, CA 92064
(858) 485-6600

The following is confidential information and is for our records only.

Patient Name (Last): _____ (First): _____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (____) _____-_____Work Phone: (____) _____-_____Cell Phone: (____) _____-_____
Email address: _____@_____.com

☐ Male ☐ Female Birthdate: ___/___/_____ Age: ____SSN: ___-___-_____ Driver's Lic# & State: _____
Employer: _____ Occupation: _____

Preferred Method of Contact: ☐ Email ☐ Text Message ☐ Cell Phone ☐ Home Phone
Spouse/Parent Name: _____ Birthdate: ____/____/_____ SSN: ____-____-_____
Spouse/Parent Employer: _____ Work Phone: (____) _____-_____
Emergency Contact: _____ Phone: (____) _____-_____Relationship:_____
Previous Dentist: _____ Phone: (____) _____-_____
Referred By: _____

DENTAL INSURANCE CLAIMS INFORMATION

Dental Insurance is a benefit purchased by, or for, the patient. We cannot be responsible for what you have purchased. ***As a courtesy, we will fill out and file a claim for you, but you are responsible for the entire bill.*** If the information you supply is incomplete or inaccurate, you will be responsible for full payment to our office and filing with your insurance carrier will be your responsibility. A monthly late fee will be assessed for non-payment on account over 60 days.

PRIMARY CARRIER:
Insurance Company: _____
Insurance Address: _____
Phone: _____ Group #: _____
Insured's Name: _____
Relationship: _____ Birthdate: _____
SSN: _____-____-_____ Subscriber ID: _____
Employer: _____

SECONDARY CARRIER:
Insurance Company: _____
Insurance Address: _____
Phone: _____ Group #: _____
Insured's Name: _____
Relationship: _____ Birthdate: _____
SSN: _____-____-_____ Subscriber ID: _____
Employer: _____

I hereby authorize the release of any information, including the diagnosis and records of any treatments or examination rendered to my Insurance company or companies. This release is solely for the purpose of facilitating billing and reimbursement directly to the Doctor of benefits to which I am entitled. I understand that a monthly late fee will be assessed for non-payment on account over 60 days. I understand a fee will be charged for missed appointments if not cancelled 48 hrs in advance by calling the office.

SIGNATURE: _____ DATE: _____

Rev 1/2019