RX ______________________________

$ _______________________________

CASH_____ CC_____ CHECK________

TEMP ______ **OFFICE USE ONLY**

Have you been in contact with anyone who has tested positive for **COVID19** within the last 2 weeks, or are you experiencing shortness of breath, fatigue, fever or coughing? Yes_________ No_________

PATIENT LEGAL NAME:____
First Name Last Name

PATIENT BIRTHDATE: ______-______-______ PATIENT SEX: MALE ☐ FEMALE ☐
Month Date Year

ADDRESS:____
Street Address or P.O. Box

____
City State Zip

PHONE: Home (_____)____________ Work (_____)_____________Cell (_____)_____________

EMAIL (optional): ____

REFERRING DOCTOR: ____

NEXT SCHEDULED APPPOINTMENT WITH DOCTOR: ________________ NOT SCHEDULED:☐

I authorize my records to be shared with the following additional Dental Specialists should they request them:

Doctor Name: ____

Dental Insurance Information (Please complete ALL fields)

Reimbursement is based on your insurance policy provisions. Having insurance coverage does not guarantee reimbursement.

Insurance Name: ___________________________ Subscriber's Name: ___________________________

Relation to patient: _____________ DOB: _______________ Employer: __________________________

Dental ID# or SS#: _________________________________ Group#: ____________________________

SIGNATURE IS REQUIRED FOR ALL PROCEDURES

- I give my permission for myself and/or child to receive X-ray services and I accept full financial responsibility for all procedures done at Diagnostic Digital Imaging (DDI).
- I understand a $15.00 fee will be charged for a returned check.
- By giving the name of your doctor, you are giving us permission to release your records to them.

X________________________________ **DATE:** ___________________
Signature of parent/guardian if patient is under 18 years old

PRINT parent or guardian name:____