Curtis E. Hahn, D.D.S.
4992 Wilson Avenue | Grandville, MI 49418
616.534.0135 | rivertowndental.com

Rivertown Dental Associates

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Personal Info

Patient Name: Last _____ First _____ Middle Initial _____ Date: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ Cell Phone: _____ E-Mail Address: _____

Social Security #: _____ Birth Date: _____

Employer: _____ Occupation: _____ Phone (work): _____

Responsible Party Information

Last name _____ First name _____ Middle Initial _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Relationship to Patient: _____ Social Security #: _____ Birth Date: _____

Phone (home): _____ Cell Phone: _____

Address *(if different from patient)*: _____

Insurance Information ☐ I do not have dental insurance

Primary

Patient's relationship to insured: ☐ Self ☐Spouse ☐ Child ☐ Other (please explain: _____)

Name of Insured: _____ Is the insured a patient? ☐Yes ☐ No

Insured's Birth Date: _____ Plan ID #: _____

Insured's Address *(if different from patient)*:_____

Insured's Employer Name: _____

Insurance Plan Name: _____ Group # _____

Insurance Carrier Phone (Toll Free # on insurance card) _____

Secondary (only necessary if you or your child are covered by more than one insurance plan)

Patient's relationship to insured: ☐ Self ☐Spouse ☐ Child ☐ Other (please explain: _____)

Name of Insured: _____ Is the insured a patient? ☐Yes ☐ No

Insured's Birth Date: _____ Plan ID #: _____

Insured's Address *(if different from patient)*:_____

Insured's Employer Name: _____

Insurance Plan Name: _____ Group # _____

Insurance Carrier Phone (Toll Free # on insurance card) _____

Consent for Services

I authorize the staff of Rivertown Dental, P.C. to perform all forms of dental treatment, medication, and therapy that may be indicated. I accept all responsibility for payment on this account. I realize that payment is due as services are rendered unless other payment arrangements have been made in writing. I consent to treatment by the staff of Rivertown Dental, P.C.

_____ Date: _____ Relationship to Patient: _____

(Signature of patient, parent, or legal guardian)

_____ Date: _____ Relationship to Patient: _____

(Signature of guarantor of payment/responsible party)