

# ~WELCOME TO OUR OFFICE~

T.L. Thomasson, D.D.S.  
Southlands Dental Associates, LLC  
6240 S. Main Street, Suite 220  
Aurora, CO 80016

To help us meet your dental needs, please fill out this form completely

Patient Name \_\_\_\_\_ Preferred Name (if applicable) \_\_\_\_\_  
\_\_\_\_\_ Male \_\_\_\_\_ Female Marital Status:  Single  Married  Other  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License# \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Mobile Phone \_\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

Responsible Party Information: **(Please fill out only if patient is under 18 years of age or different from the Patient Information)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Mobile Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

I certify that the above information is true and correct and will notify this office immediately of any changes. I understand that responsibility for payment of dental services in this office for myself and/or my dependents is mine, due and payable at the time of service. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by my insurance.** I give my authorization and consent for treatment after having a full explanation by the doctor and/or staff regarding the proposed treatment, alternatives and/or risks.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# INSURANCE INFORMATION

Southlands Dental Associates, LLC  
6240 S. Main Street, Suite 220  
Aurora, CO 80016

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insured's Address \_\_\_\_\_  
Insured's Birthdate \_\_\_\_\_ Insured's SS# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Employer \_\_\_\_\_ Employee ID # \_\_\_\_\_

## Dental Insurance

Insurance Company \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_ Insurance Fax # \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

## Additional Dental Insurance

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Insured's SS# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_ Insurance Fax # \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

I hereby authorize assignment of benefits to be directly payable to the above named dental entity if this is a Delta Dental, MetLife, Ascent, Humana, Guardian, Assurant, Dental Guard, Principal, United Concordia, Aetna, Premier Dental, or Cigna claim. I acknowledge that my signature on this document authorizes the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation by the doctor and/or staff regarding the proposed treatment. I certify that the above information is complete, thorough and correct and I will notify this office of any changes.

Signature \_\_\_\_\_

Date \_\_\_\_\_



# Southlands Dental Associates

Thomas L. Thomasson, DDS

6240 S. Main Street, Suite 220

Aurora, CO 80016

303-400-4865

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## **For all Participating Dental Insurance Plans**

I understand that all co-payments are due at the time of service. I understand that all benefits quoted are an estimate and that this office cannot be responsible for insurance limitations, exclusions, deductibles, downgrades or plan designs. I understand that I am fully responsible for any amount not covered by my insurance company and agree to pay the amount due within 15 days of notification by this office. I will provide this office with all pertinent information regarding my insurance company so that a claim can be filed on my behalf. \_\_\_\_\_ **Patient's Initials**

## **Medical Insurance**

I understand that all payment is due at the time of service. I also understand that this office cannot guarantee that my insurance company will pay for all or any portion of my treatment. I will provide this office with all pertinent information regarding my insurance company. I understand that as a courtesy a claim will be filed on my behalf and that all reimbursements will be sent directly to the insured.

## **Auto Insurance (for all accident related injuries not on a lien):**

I understand that all payment is due at the time of service for all services performed by Southlands Dental Associates. I will provide this office with all pertinent information regarding my insurance company. I also understand that this office cannot guarantee that my insurance company will pay for all or any portion of my treatment. I understand that as a courtesy a claim will be filed on my behalf and that all reimbursements will be sent directly to the insured.

## **Missed Appointments:**

**Our office understands that your time is very valuable and we will do our best to provide timely cooperation in making and keeping appointments. Therefore, we will ask the same courtesy from you. It is our office policy that we require 24 hours advance notice to cancel an appointment. Failure to provide 24 hours notice, regardless of the situation, will result in a \$50 short notice cancellation fee. This fee is due from the patient and not the insurance company. \_\_\_\_\_ Patient's Initials**

My signature is an acknowledgement that I have read and agree to comply with the policies listed above.

Signature \_\_\_\_\_ Date \_\_\_\_\_