Kevin T. Larson D.M.D.

9370 SW Greenburg Rd Grant Building, North, Suite D
Portland, Oregon 97223 503-245-6441

Patient Information (Confidential)

Last | First | MI | Preferred Name

Home address | City | State | Zip

Cell Phone | Home Phone | Work Phone

Email | SSN | Birthdate

Patient's Sex: ◯ Male ◯ Female ◯ Minor ◯ Married ◯ Single ◯ Divorced ◯ Widowed

If Student (for insurance purposes)

School Name | City | State | ◯ Full Time ◯ Part Time

Employer | Occupation

Spouse/Parent/Guardian Name | Phone

Emergency Contact | Phone | Relationship

How did you find us?

Insurance Information

Name of Insured | Birthdate

Relationship to Patient | Insured's Employer

Insurance Company | ID or SSN | Group #

Insurance Address | Phone

Do you have additional Insurance? If Yes, complete the Following

Name of Insured | Birthdate

Relationship to Patient | Insured's Employer

Insurance Company | ID or SSN | Group #

Insurance Address | Phone

Our office maintains a list of Insurance companies that we will bill automatically. Insurance claims are completed as a courtesy for you, without charge. We do not accept the responsibility for collecting your claim. You are responsible directly to Dr. Kevin T. Larson for payment of your account within 30 days of the billing date, unless other arrangements have been agreed upon, regardless of the status of your insurance claim. You will receive a statement each month even though an insurance claim is pending. I authorize the release of any information necessary to process my insurance claims. I authorize payment of dental benefits directly to Dr. Kevin T. Larson. I understand that I am financially, responsible to Dr. Kevin T. Larson for any charges not covered by insurance.

I understand the above credit policy and agree to accept responsibility for full payment of my account.

Signature | Date

For your convenience, we offer the following methods of payment: cash, personal check, Visa or Mastercard.