

**Star Ranch Dental Spa
Peter R. Barnett, DMD, P.A.
5944 W. Parker Road, Suite 500
Plano, TX 75093
972/943/5944**

Patient Information

Name: _____
Last First M.I.

Address: _____
Street City State Zip

Phone: _____ (Home)
_____ (Work)
_____ (Cell)
_____ (Email Address)*

* We utilize email for appointment reminders, sending you copies of your insurance payments, and other business items. We promise we will not share your email address.

We pride ourselves on trying to see you at the time of your scheduled appointment. If we have an emergency or unplanned procedure, we will try to reach you so you can plan accordingly. In return, we would appreciate a *48 hour notice* for any appointment change or cancellation.

_____ *Signature*

*We currently accept most PPO (in network) insurance. We will file any insurance claim electronically **and expect you to pay any out of pocket on the day of service. If we are not in your network and your insurance company does not pay us within 30 days, you will be responsible for any unpaid balances.** By signing this form, you are agreeing to pay the specified amount immediately upon notification. Unfortunately, we cannot take any HMO or DMO plans as we are not an approved provider. Please provide us with the following information, with a copy of your insurance card and driver's license:*

Insurance Company: _____

Insurance Company Address: _____

Employer Name: _____

Insured's Name: _____ D.O.B. _____

Insured's/Subscriber's SS#: _____ Group Name: _____

Patient's SS#: _____ D.O.B. _____