Patient Information

Date_____

Name_____ Birthdate_____ SS#_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Status: □ Minor □ Single □ Married □ Divorced □ Widowed

Patient's Employer_____ Work Phone_____

Spouse's Employer_____ Work Phone_____

If minor, please complete: Mother's Name_____ Employer_____

Home phone _____ Work phone_____

Father's Name_____ Employer_____

Home Phone_____ Work Phone_____

If patient is a student, Name of School or College_____ City/State_____

Whom may we thank for referring you?_____

Billing Information

Person responsible for the account_____ Relationship to patient_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Employer_____ Work Phone_____

Is this person currently a patient in our office? □ Yes □ No

Insurance Information

Policy Holder's Name_____ Relationship to patient_____

Policy Holder's Birthdate_____ Policy Holder's SS#_____

Policy Holder's Employer_____ Work Phone_____

Name of Insurance Company_____ Group #_____

Insurance Company Address_____ City/State_____ Zip_____

Secondary Dental Insurance Information

Policy Holder's Name_____ Relationship to patient_____

Policy Holder's Birthdate_____ Policy Holder's SS#_____

Policy Holder's Employer_____ Work Phone_____

Name of Insurance Company_____ Group #_____

Insurance Company Address_____ City/State_____ Zip_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or practitioners. I authorize and request my insurance to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier is responsible to me and not my dental office and may pay less than the actual services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or parent if minor