Patient Information

First Name: _____ MI:_____ Last Name:_____ Sex: ☐ Male ☐ Female

Preferred Name: _____ Date Of Birth: _____ Social Security #:_____

Address:_____City:_____ State:_____Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Primary Contact Number: ☐ Home ☐ Work ☐ Cell Best Time To Call:_____

Email:_____Fax:_____ Driver's License #:_____

Employer:_____ Occupation:_____

Spouse's Name:_____ Spouse's Employer:_____

Whom may we thank for referring you?:_____

If the patient is a child:

School:_____ School Phone:_____ Grade:_____

Person Financially Responsible for Account (if the patient is an adult, please skip to payment method)

Full Name:_____ Relationship to Patient:_____

Social Security #:_____ Phone:_____ Driver's License #:_____

Date Of Birth:_____ Employer:_____

Emergency Contact(s)

Full Name:_____ Relationship to Patient:_____

Address:_____City:_____ State:_____Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Full Name:_____ Relationship to Patient:_____

Address:_____City:_____ State:_____Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Dental Insurance

Primary Carrier

Insurance co. name:_____ Insurance co. phone:_____

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

Group no. (Plan or Policy no.)_____ Insurance I.D. no. :_____

Insured's name:_____ Relationship to Patient:_____

Date of Birth:_____ Insured's social security no. :_____ Employer Name:_____

Secondary Carrier

Insurance co. name:_____ Insurance co. phone:_____

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

Group no. (Plan or Policy no.)_____ Insurance I.D. no. :_____

Insured's name:_____ Relationship to Patient:_____

Date of Birth:_____ Insured's social security no. :_____ Employer Name:_____

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient Signature:_____ Date:_____