Patient Information

Today's Date: ______________________

Name: Mr, Mrs, Ms, Dr ______________________

I prefer to be called: ______________ ❒ Male ❒ Female

Birthdate: ______________________

Social Security #: ______________________

Home Address: ______________________

______________________ Zip Code ______________

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Legally Separated

Home #: ______________________

Cell #: ______________________

Wk #: ______________________

Name & Phone # of nearest relative or friend:

____

Employer: ______________________

Whom may we Thank for referring you?

____

Spouse/Parent Information

His/Her Name: ______________________

Employer: ______________________

Wk #: ______________________

Social Security #: ______________________

Birthdate: ______________________

Person Responsible for Account: ______________________

Wk #: ______________ Ext.: ____ HM #: ______________

Billing Address: ______________________

Relationship: ____________ Social Security #: ____________

Employer: ______________________

Dental Insurance

PRIMARY DENTAL INSURANCE

Insurance Co. Name: ______________________

Insurance Co. Tel. #: ______________________

Group # (Plan, Local or Policy #): ______________________

Insured's Name: ______________________

Relation: ______________________

Insured's Birthday: ______________________

Insured's Social Security #: ______________________

Insured's Employer: ______________________

SECONDARY DENTAL INSURANCE

Insurance Co. Name: ______________________

Insurance Co. Tel. #: ______________________

Group # (Plan, Local or Policy #): ______________________

Insured's Name: ______________________

Relation: ______________________

Insured's Birthday: ______________________

Insured's Social Security #: ______________________

Insured's Employer: ______________________

Method of Payment

For our patients with dental insurance, you will be responsible for your co-payment on the day of treatment. We will try to obtain benefit information from your insurance. This will be an "estimate" only and not a guarantee of payment. For our patients without dental insurance, payment will be due in full at the time of treatment. ***Notice:*** A fee will be charged for missed appointment of less than 24 hours notice.

Authorization

The information on this page and my medical history are correct to the best of my knowledge. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand I am financiallyresponsible for all charges whether or not paid by insurances. I hereby authorize this Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Signature: ______________________________ Date: ______________________

❒ *Parent/Patient* ❒ *Father* ❒ *Mother* ❒ *Guardian*