WELCOME TO OUR PRACTICE!

PATIENT INFORMATION

TODAY'S DATE:_____/_____/_____

NAME_____ GENDER: ☐ M ☐ F AGE_____
FIRST MI LAST

BIRTH DATE:_____/_____/_____ SS#_____ FAMILY STATUS: ☐ MINOR ☐ S ☐ M ☐ W ☐ SEP ☐ D

ADDRESS_____APT#_____CITY_____STATE_____ZIP_____

PHONE: MOBILE (_____)_____ REFERRED BY: ☐ Insurance ☐ Internet ☐ Yellow Pages ☐ Sign ☐ Other

HOME (_____)_____ ☐ Friend/Family Member_____

WORK (_____)_____EXT_____ EMPLOYER:_____

OTHER (_____)_____ E-MAIL ADDRESS:_____

Has any member of your family ever been to our office before: ☐ No ☐ Yes (if yes) Who?_____

Emergency Contact:_____ Relationship to Patient_____

Mobile:_____ Home:_____ Work:_____ Ext:_____

SPOUSE or PARENT/GUARDIAN INFORMATION

NAME_____ GENDER: ☐ M ☐ F
FIRST MI LAST

BIRTH DATE_____/_____/_____ SS#_____ RELATIONSHIP TO PATIENT:_____

ADDRESS_____APT#_____ CITY_____STATE_____ ZIP_____

MOBILE (_____)_____ HOME (_____)_____ WORK (_____)_____EXT_____ OTHER_____

EMPLOYED BY_____ OCCUPATION_____

PRIMARY DENTAL INSURANCE INFORMATION (Please present your insurance card to be copied)

SUBSCRIBER'S NAME_____ RELATION TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

SUBSCRIBER'S DOB____/_____/_____ SS#/ID#_____ INSURANCE COMPANY_____

SUBSCRIBER'S EMPLOYER_____ GROUP# _____

NAME OF OTHER DEPENDENTS COVERED UNDER THIS PLAN INSURANCE ADDRESS_____

_____ DOB _____/_____/_____ _____

_____ DOB _____/_____/_____ PHONE NO. TO VERIFY BENEFITS_____

_____ DOB _____/_____/_____

SECONDARY DENTAL INSURANCE INFORMATION (Please present your insurance card to be copied)

SUBSCRIBER'S NAME_____ RELATION TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

SUBSCRIBER'S DOB____/_____/_____ SS#/ID#_____ INSURANCE COMPANY_____

SUBSCRIBER'S EMPLOYER_____ GROUP# _____

NAME OF OTHER DEPENDENTS COVERED UNDER THIS PLAN INSURANCE ADDRESS_____

_____ DOB _____/_____/_____ _____

_____ DOB _____/_____/_____ PHONE NO. TO VERIFY BENEFITS_____

_____ DOB _____/_____/_____

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS AUTHORIZATION

* I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
* I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
* I authorize release of any information concerning my (or my child's) healthcare, advice and treatment to any referring dentist.
* I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
* I understand that all dental services are charged directly to me and that I am financially responsible for payment of all dental treatment.
* I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services rendered, and agree to be responsible for payment of all services not paid for in full, or in part, by my dental insurance.
* I attest to the accuracy of the information on this page.

Signature_____ Print Name_____ Date_____