Welcome

Thank you for choosing us for your dental care needs. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to contact us.

PATIENT INFORMATION

Patient Name: ____ Social Security #: ___________________
(Last Name) (First Name) (MI)

Birth Date: ___________________ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Email Address: _______________________________________ Main Phone #: _________________________

Street Address: ____ Work #: _________________________

City: _________________ State: _______ Zip Code: __________ Occupation: ___________________________

DENTAL INSURANCE

Insured/Individual Responsible for this account:

____
(Last Name) (First Name) (MI)

SS #: ______________ Driver's Lic. #: ________________

Birth Date: _________ Relationship w/ Patient: _______

Street Address (if different):

____

City: _______________ State: _____ Zip Code: ________

Main #: _________________ Work #: ________________

Responsible Party Employed by: ___________________

Insurance Company: _____________________________

Phone #: ____________________________

Group #: ________________________

Subscriber/Member ID #: ___________________________

SECONDARY INSURANCE

Insured Individuals Name:

____
(Last Name) (First Name) (MI)

SS #: ________________ _ Birth Date: _______________

Relationship w/ Patient: ___________________________

Street Address (if different):

____

City: _______________ State: _____ Zip Code: ________

Main #: _________________ Work #: ________________

Responsible Party Employed by: ___________________

Insurance Company: _____________________________

Phone #: ____________________________

Group #: ________________________

Subscriber/Member ID #: ___________________________

Whom may we thank for referring you to us? ____

IN CASE OF EMERGENCY CONTACT:

Name: ____ Relationship to Patient: _______________________

Main Phone #: ________________________________ Alternate Phone #: _____________________________________

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other dental insurance" is indicated on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. **Payment is due in full at time of treatment unless prior arrangements have been approved.**

Signature: ____ Date: ______________________