PATIENT INFORMATION

Name ____
Last First
Address __________________________________ Apt.# _________
City ___________________________________ Zip ____________
How long at this address? __________________________________
Phone ____
Cell Phone ____
Email ____
Social Security # ____
DL# ____
Age ______________ Birthdate ____________________________

List any family members who may need dental care and their relationship?
1.________________________ 2. ________________________
3.________________________ 4. ________________________

How did you hear about our office?

Family/Friend Insurance Plan
Flyer/Coupon Groupon
Office Sign Internet/Website
Referred by Patient ____________________________________
Referred by Doctor _____________________________________
* I want information in Spanish: Yes______ No______

RESPONSIBLE PARTY (If same as above, please skip)

Name ____
Last First
Address ____
City _______________________________ Zip ________________
How long at this address? __________________________________
Phone ____
Social Security # _________________________ DL# ______________
Age _____________ Birthdate _______________________________

DENTAL INSURANCE (Primary Plan)

Insurance Company: ______________________________________
Address ____
City _______________________________ Zip _______________
Insurance Phone ____
Subscriber ID# _______________________ Group # ____________
Subscriber Birthdate ______________________________________
Employer ____

EMPLOYMENT

Occupation ____________________________How Long?____________
Employer _____________________________Phone _______________
Business Address ____
City _________________________________ Zip ________________

EMERGENCY CONTACT

Name ____
Last First
Phone___________________ Relationship ______________________
Physician _________________________ Phone __________________

DENTAL INSURANCE (Secondary Plan)

Insurance Company: ______________________________________
Address ____
City _______________________________ Zip _______________
Insurance Phone ____
Subscriber ID# _______________________ Group # ____________
Subscriber Birthdate ______________________________________
Employer ____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

____ _________________________
Signature of Patient or Responsible Party Date