Patient Information

Date:____________ Home Phone: ___________________ Work Phone:___________________Cell:___________________

Name:_________________________________ Social Security Number: _____- ____- _____ Email:_______________

Address: ____City: _____________ State: ______ Zip: _______________

Sex: M ☐ F ☐ Birthdate:____________________________ ☐Minor ☐Single ☐Married ☐Widowed ☐Divorc

Patient Employed By: _______________________________ Business Address: __________________________________

Whom may we thank for referring you: ____

In case of emergency who should be notified: _______________________________________ Phone: _________________

Responsible Party

Name of person responsible for the account: ____Phone:______________

Address of responsible party: ________________________________City: ____________ State: ______ Zip: __________

Relationship to the patient: ___________________________ Birthdate:_______________ SSN: ______ ______ ______

Dental Insurance Information

Name of the Insured:____Relationship to Patient: ____________________

Insured's Date of Birth: ____________________ SSN: ______- ______- ______ Employer: ________________________

Insurance Company: ____ Phone: ___________________________

Group Number: ____________________________________ Employee/Cert. Number: ____________________________

Insurance Company Address: _________________________________City: ____________ State: ______ Zip: ________

Deductible: ______________ Amount Already Used: _________________ Maximum Annual Benefit: _________________

Do you have Secondary Insurance Coverage: Yes ☐ No ☐ If yes, please complete the following information:

Name of Insured: ___________________________________ Relationship to Patient: ______________________________

Insured's Date of Birth: ____________________ SSN: ______- ______- ______ Employer: ________________________

Insurance Company: ____ Phone: _____________________________

Group Number: ____________________________________ Employee/Cert. Number: ____________________________

Insurance Company Address: _________________________________City: ____________ State: ______ Zip: ________

Deductible: ______________ Amount Already Used: _________________ Maximum Annual Benefit: _________________

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dent I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on m behalf or my dependents.

Signature of Patient or Parent if Minor: ____ Date: __________________

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