PATIENT INFORMATION

NAME ___________________________________

☐ MALE ☐ FEMALE

DOB ____/____/______

□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered

Address

____

City __________________________ State _____
Zip __________

Home Phone _________________________
Cell Phone ___________________________
Work Phone _________________________
E-mail

____

Patient employer/School

____

Whom may we thank for referring you?

____

SPOUSE/ PARTNER/ or PARENT INFORMATION

Name __________________________________

Employer _______________________________

Work Phone ________________________

Cell Phone _________________________

DOB ___/___/____

In the event of an emergency is there someone who lives near that we should contact?

Name: _______________________________
Relation :____________________________
Home Phone: _________________
Cell Phone: ___________________

Who is responsible for this account?

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Insurance Co. ______________________________

Insurance Address __________________________

Insurance Phone _____________________

Group # ___________________________

Insured Name ______________________________

Relationship to patient ____________________

Insured's DOB ___/___/____

Insured's SSC/ID # _________________________

Insured's Employer _________________________

SECONDARY DENTAL INSURANCE

Insurance Co _____________________________

Insurance Address __________________________

Insurance Phone _________________________

Group # _______________________________

Insured's Name ____________________________

Relationship to patient ___________________

Insured's DOB ___/___/____

Insured's SSC/ID # ________________________

Insured's Employer ________________________

Assignment and Release
I certify that **if** I and/or my dependent(s), have insurance coverage will assign all insurance benefits directly to the DDS , if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The DDS may use my health care information and may disclose such information to the my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.
Financial Responsibilities
I understand that I am **financially responsible** for all charges whether or not paid by insurance or if I have **no insurance.**

Appointments
We do ask for **48 Business Hours** notice for an appointment change to avoid a late change fee.

Authorization & Signature

x____________________________________ date __________

x_____________________________________date _________

x date