PATIENT INFORMATION **(confidential)**

Today's Date ________________ Patient Acct. No. ____________________________

Patient's Name ____________________________________ Birthdate _______________ Soc. Sec. # ______________________

Has the patient been seen in our office in the past? _____ Yes ______ No

☐ Minor/Student ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex ☐ Male ☐ Female

Address ____ City _______________ State __________ Zip Code _________

Home Phone (_____) ____________________ Cell Phone (_____) ____________________ Pager (_____) ________________

E-Mail ____ I would like to receive correspondence via e-mail Yes or No

Patient's Employer____________________________________ Occupation ______________________ How Long? ________

Employer Address _____________________________________ City _______________ State __________ Zip Code _________

Work Phone (____) _________________ Ext. __________ May we contact you at work ___ Yes ___ No

Spouse or Parent's Name ____

Employer ____ Work Phone (____) ____________________ Ext. ______

Referring Dentist ____ Office Phone (____) _______________

Person to Contact in Case of Emergency ____ Phone (____) _______________

RESPONSIBLE PARTY **(if other than patient)**

Name of Person Responsible for this Account ______________________________ Relationship to Patient ________________

Soc. Sec. #___________________________________ Birthdate ________________ Home Phone (____) _______________

Address ____ City _______________ State __________ Zip Code _________

Employer ____ Work Phone (____) ____________________ Ext. ______

INSURANCE INFORMATION

Dental Insurance Company ______________________________ Policy No. __________________ Group No. _______________

Name of Insured _________________________________ Relationship to Patient _________________ Birthdate ______________

Insured's Employer____ Work Phone (____) __________________ Ext. ______

DO YOU HAVE A SECONDARY DENTAL INSURANCE? _____ Yes _____ No (IF YES, COMPLETE THE FOLLOWING)

Secondary Dental Insurance Company ______________________ Policy No. __________________ Group No. _____________

Name of Insured _________________________________ Relationship to Patient _________________ Birthdate ______________

Insured's Employer____ Work Phone (____) __________________ Ext. ______

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is expected at each appointment.

_______ Cash _______ Check _______ Credit Card (Mastercard, Visa, Discover or American Express) _______ Financing

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due in full when services are rendered. I understand this office is not a provider of my insurance and insurance may pay less than the actual bill of services. I authorize this office to bill my insurance and send any information needed to process my dental claim by mail, fax and/or by e-mail.

Signature ____ Date ________________

Relationship (if signed by authorized agent of Patient) ____