Please Complete The Following Confidential Information

Patient Information

Patient's Name: _____ Gender: ___Male ___ Female
First Middle Last Nickname

Date of Birth: _____ Marital Status (circle one): Single Married Divorced Widowed Separated

Spouse or Parent's Name: _____ SSN#: _____

Home Address: _____
Street City State Zip

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Email Address: _____ Whom may we thank for referring you to our office? _____

Emergency Contact Name: _____ Phone: (___) _____

Responsible Party Information

Name: _____ Date of Birth: _____

Relationship to patient: _____ Social Security #: _____

Address: _____
Street City State Zip

Home Phone: (___)_____ Work Phone: (___)_____

Employer: _____ Occupation: _____

Dental Insurance Information

Name of Insured: _____ Relationship to patient: _____

Date of Birth: _____ Social Security #: _____ Employer: _____

Insurance Company: _____ Group #: _____

Insurance Company Address: _____ Phone: (___)_____

Dual Coverage? Yes___ No___ If yes, please inform the front desk.

I authorize release of any information relating to this claim. I also authorize and request my dental insurance company to pay the dentist directly including dental group insurance benefits otherwise payable to me.

Signature of patient/parent: _____ Date: _____

Office Payment Policy

Doctor and patient relationships are enhanced when there is a complete understanding of the treatment rendered and the fee. We understand insurance is a contract between you, your employer, and the insurance carrier. As a courtesy, we will submit insurance on your behalf and we will determine as closely as possible what your estimated portion will be prior to the beginning of treatment. Payment is required for the estimated portion that is not covered at the time of treatment. If a balance remains on your account after insurance has paid, you will be responsible for the difference.

For your convenience we offer the following methods of payment: Cash, Check, Visa, MasterCard, Discover, and Care Credit.

Signature: _____ Date: _____