Financial and Demographic Information

Patient Name _____ Nickname _____
Date of Birth _____
Person financially responsible: _____ Relationship to you _____
□I am under 21 and a dependent of my parents. I agree to the release of my records to my parents.
Home address _____ Home phone _____
City _____ State ____ Zip _____ Work phone _____
Billing address _____ Cell phone _____
City _____ State ____ Zip _____ Email _____
Social Security Number _____
Marital Status _____ Spouse/Partner's name _____
Referred by _____
Patient occupation _____ Employer _____
Primary Physician _____ Phone _____
Former/Regular Dentist _____ Date of last dental visit _____
Address _____
Emergency Contact _____ Phone _____
□Spouse □Relative □Friend

Primary Dental Insurance

Name of Policy Holder _____
Policy Holder Phone # _____
Relationship to patient _____
Policy Holder's ID _____
Policy Holder's Birthdate _____
Insur. Company _____ Group # _____
Insur. Co. Address _____
Policy Holder's Place of Employment _____

Secondary Dental Insurance

Name of Policy Holder _____
Policy Holder Phone # _____
Relationship to patient _____
Policy Holder's ID _____
Policy Holder's Birthdate _____
Insur. Company _____ Group # _____
Insur. Co. Address _____
Policy Holder's Place of Employment _____

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the 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 dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

Date _____ Signature _____

Please initial to confirm you have read our OFFICE POLICIES. _____
Please initial to confirm that we DO NOT BILL MEDICARE. _____