DEMOGRAPHIC AND FINANCIAL INFORMATION

Patient Information

Patient Name _____ Date of Birth _____

Preferred Name _____ Social Security Number _____

Home address _____ Billing address _____

City _____ State ____ Zip _____ City _____ State ____ Zip _____

Patient occupation _____ Employer _____

Referred by _____

Primary Physician _____ Phone _____

Former/Regular Dentist _____ Date of last visit _____

Emergency Contact

Name _____ Phone _____

Responsible Party

Person financially responsible: _____ Relation to patient: _____

Primary Dental Insurance

Policy Holder _____

Relation to patient _____

Policy Holder's DOB _____

Insurance Company _____

Policy Holder's ID _____

Group # _____

Secondary Dental Insurance

Policy Holder _____

Relation to patient _____

Policy Holder's DOB _____

Insurance Company _____

Policy Holder's ID _____

Group # _____

Medical Insurance

Policy Holder _____

Relation to patient _____

Policy Holder's DOB _____

Insurance Company _____

Policy Holder's ID _____

Group # _____

***Do you have Medicare? Yes / No**

*Please **initial here**_____ to confirm that we **DO NOT BILL MEDICARE** or Medicare supplemental plans. We are opted out of Medicare. Payment is due at time of service.

***Do you have Medicaid? Yes / No**

*Please **initial here**_____ to confirm that we **DO NOT BILL MEDICAID** and payment is due at time of service.

Authorization & Release

I certify that the above questions have been accurately answered. I authorize the dentist to release any information and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. 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 dependent's behalf.

Date _____ Signature _____