PATIENT INFORMATION

Date_____

Name_____ **Birthdate**_____ **Phone:(___)**_____

First Middle Last

Address_____ **City**_____ **State**_____

Zip_____ **Cellphone:**_____ **Email:**_____**@**_____

Social Security # _____

Check Appropriate Box: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Spouse or Guardian's Name_____

Patient's or Guardian's Employer_____ **Work**

Phone(___)_____

If our office needs to contact you, is it OK to call you at work? ☐ **YES** ☐ **NO**

Name of Person Responsible for this Account, if different from Patient_____

Phone(___)_____

Address_____ **City**_____ **State**_____

Zip_____

Social Security # of Responsible Person for this account. _____

If Patient is a Student, Name of

School/College_____

Address_____ **City**_____ **State**_____

Zip_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of an Emergency_____

Phone(___)_____

TO OUR PATIENTS WITH DENTAL INSURANCE:

Our office policy is to submit your claim to your insurance company. You are responsible for any co-payments and deductibles at the time of treatment, unless other financial arrangements have been made in advance. Your signature below, will give us permission to send your claim to your insurance company. It will also assign your benefits to our office, this way you will only be responsible for what your insurance carrier does not cover.

TO OUR PATIEINTS WITHOUT DENTAL INSURANCE:

Our office policy is payment at the time of treatment, unless other arrangements have been made in advance.

If needed, our office will be able to help you arrange a payment plan or financing. We accept cash, checks, Visa, Mastercard, and Discover and Amex.

ANY CANCELLED OR MISSED APPOINTMENTS WITHOUT 48 HOUR NOTICE IS SUBJECT TO A "FAILED APPT. FEE"_____(INITIAL)

X

SIGNATURE

Signature of Patient or Guardian

DENTAL AND MEDICAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Name of Insured: _____ Relationship to patient_____
Birthdate: _____ Social Security Number of Policy Holder:
_____
Name of Employer:_____ Work Phone:
_____
Address of Employer: _____ City: _____ State: _____ Zip:
_____
Insurance Company: _____ Group #: _____ Union or Local #
_____
Ins. Co. Address _____ City: _____ State: _____ Zip:
_____
Insurance Company Phone Number:_____

SECONDARY DENTAL INSURANCE

Name of Insured: _____ Relationship to patient_____
Birthdate: _____ Social Security Number of Policy Holder:
_____
Name of Employer:_____ Work Phone:
_____
Address of Employer: _____ City: _____ State: _____ Zip:
_____
Insurance Company: _____ Group #: _____ Union or Local #
_____
Ins. Co. Address _____ City: _____ State: _____ Zip:
_____
Insurance Company Phone Number:_____

PRIMARY MEDICAL INSURANCE

Name of Insured: _____ Relationship to patient_____
Birthdate: _____ Social Security Number of Policy Holder:
_____
Name of Employer:_____ Work Phone:
_____
Address of Employer: _____ City: _____ State: _____ Zip:
_____
Insurance Company: _____ Group #: _____ Union or Local #
_____
Ins. Co. Address _____ City: _____ State: _____ Zip:
_____
Insurance Company Phone Number:_____

SECONDARY MEDICAL INSURANCE

Name of Insured: _____ Relationship to patient_____
Birthdate: _____ Social Security Number of Policy Holder:
_____

Name of Employer:_____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Union or Local # _____

Ins. Co. Address _____ City: _____ State: _____ Zip: _____

Insurance Company Phone Number:_____

DO YOU HAVE A PREFERRENCE FOR APPOINTMENT TIMES?
IF YES, PLEASE
LIST:_____

CAN WE CALL YOU ON SHORT NOTICE IF WE GET AN OPENING IN OUR SCHEDULE? ☐YES ☐NO