

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ CELL PHONE _____ HOME PHONE _____

Would you like to receive correspondence via email? YES NO Would you like to receive correspondence via text? YES NO

DRIVER'S LICENSE # _____ STATE OF ISSUE _____

SS# _____ BIRTHDATE _____ MALE FEMALE

CHECK APPROPRIATE BOX MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

IF COLLEGE STUDENT, FT/PT, NAME OF SCHOOL _____ CITY _____ STATE _____

PATIENT OR PARENT'S EMPLOYER _____ WORK PHONE _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE# _____ BIRTHDATE _____ SS# _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ TELEPHONE # _____

POLICY # _____ GROUP # _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES NO *IF YES, COMPLETE THE FOLLOWING:*

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ TELEPHONE # _____

POLICY # _____ GROUP # _____

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

X _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN, IF MINOR

DATE