WELCOME

ABOUT YOU

Today's Date_____

Patient Name_____

DOB___/____/_____ Age_____ M_____F_____

Social Security #_____

Address_____

_____

(CITY) (STATE) (ZIP)

Home Phone_____

Cell Phone_____

Email Address_____

Employer_____ Occupation_____

Status- O Minor O Single O Married

Account Info

Who is responsible for account?_____

Relationship_____

Billing Address_____

_____

(City) (State) (ZIP)

Drivers License #_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

_____

(Signature)

Insurance Info

Primary Dental Insurance Company_____

Address_____

Insurance ID #_____Phone #_____

Primary Insured Name_____DOB__/__/___

Relationship_____Group #_____

Insured Employer_____

Secondary Dental Insurance Co_____

Address_____

Insurance ID #_____Phone #_____

Insured Name_____DOB__/__/____

Relationship_____Group #_____

Insured Employer_____

Emergency Contact Info

Name_____

Relationship_____

Home Phone #_____

Cell Phone #_____

Work Phone #_____

Who is your medical doctor?_____

Medical Dr. Phone #_____