Patient Information Today's Date _____

Patient Name: Last _____ First _____ MI _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced Nickname _____

SS # _____ Driver's Lic # _____ Birth Date _____

Cell Phone _____ Home Phone _____ Work Phone _____

Ok to Text ☐ Ok to Email ☐ Email _____

Address _____ City _____ St. _____ Zip _____

Physician's name _____ Physician's # _____

Employer _____ Occupation _____

Spouse's Name _____

Billing Address (if different) _____ City _____ State _____ Zip _____

Emergency contact (other than spouse): Name _____ Relation to patient _____

Phone H/W/Cell _____ **Whom may we thank for referring you?** _____

Person Responsible for Account

Last _____ First _____ MI _____

SS # _____ Driver's Lic # _____ Birth Date _____

Employer _____ Occupation _____

Home Phone _____ Work Phone _____ Ext _____ Best time to call _____

Address _____ City _____ State _____ Zip _____

Insurance Information

Primary:

Name of Insured: Last _____ First _____ MI _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Employer's Name _____

Insurance plan Name and Address _____

If active military; rank: ☐ E4&under ☐ E5&above ☐ Officer

Insured's Birth date _____ SS # _____

Group # _____ ID # _____

Insured's Address _____

Secondary:

Name of Insured: Last _____ First _____ MI _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Employer's Name _____

Insurance plan Name and Address _____

If active military; rank: ☐ E4&under ☐ E5&above ☐ Officer

Insured's Birth date _____ SS # _____

Group # _____ ID # _____

Insured's Address _____

AUTHORIZATION AND 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 understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the 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 payers 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 dental 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.

X _____

Signature of patient (or parent if minor)