Welcome

Patient's Name ____ Date of Birth _______________ ☐ Female
Last First Initial ☐ Male

How do you wish to be addressed: ______________________

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Street Address: ____________________________________

City ________________ State_____ Zip _______________

Cell Phone #: (____) ______ - ________

Home Phone #: (____) _____- _______

Office Phone #: (____) _____ - _______

E-mail Address: ____________________________________

Patient Employer: __________________________________

Present Position: _________________________

How Long Held: ___________________________

Spouse Name: ______________________________

Spouse Employed By: ______________________________

Present Position: _______________________________

How Long Held: _____________________

Who Is Responsible for this Account: _____________________

Driver's License No. __________________________

Whom may we thank for this referral _____________________

Patient Social Security No. _____________________________

Spouse Social Security No. _____________________________

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I attest to the accuracy of the information on this page.

Patient's Signature ____

Date ______________________________

Primary Dental Insurance

Employee Name _______________

Date of Birth __________________

Relationship to patient ____________________

Employer Name _________________________

Name of Insurance Co. _____________________

Address ________________________________

____

Telephone No. __________________________

Policy/ Group # _______________________

ID # _____________________________

Secondary Dental Insurance

Employee Name ______________________

Date of Birth ____________________

Relationship to patient ____________________

Employer Name _______________________

Name of Insurance Co ______________________

Address _______________________________

____

Telephone No _______________________

Policy Group # ________________________________

ID # _________________________________