Patient's Information

Patient's Name____
First *Last*

Male ☐ Female ☐ Married ☐ Single ☐ Birth date ______________ Soc. Sec.#____________________

Address______________________________ City ____________________ Zip__________

Home Phone ________________ Work Phone______________ Cell Phone______________

Employer __________________________ Occupation__________________________

Business Address ____

Has a family member ever been to our office? Yes_____ No_____ Their name ____________________

Whom may we thank for referring you to our office? ______________________________

Insurance's Information

Person Responsible for account______________________________________
First *Last*

Birth date______________ Soc. Sec.#__________________ Relation to Patient______________
(Self,spouse,child,etc)

Employed by ____

Business Address ____

Insurance Company ____

Contract #__________________ Group #________________ Subscriber #________________

Signature

1. I authorize the release of information to all my insurance carriers.
2. I authorize payment directly to my doctor.
3. I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
4. I understand that I am financially responsible for Dental charges not covered by my insurance.

Name:____(please print)

Signature____________________________________ Date ______________________