

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT NEATLY

Name:		Legal Name:
Mailing Address:		911 Address:
City:	State:	ZIP:
County:		
Home Phone:	Work Phone:	Cell Phone:
	Ext.	Text Appointment Reminders: <input type="checkbox"/> YES <input type="checkbox"/> NO
e-mail address:		Daytime call me at : <input type="checkbox"/> Home <input type="checkbox"/> Work
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Soc. Security #:	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	Spouse name:
Employer:	Occupation:	
Business Address:	City, State, ZIP:	

Whom may we thank for referring you?

RESPONSIBLE FOR ACCOUNT

Name of person responsible for account:		Relationship:
Address: (If different from above)		Phone:
City, State, ZIP:	Soc. Security #:	Date of Birth:

DENTAL INSURANCE INFORMATION

Name of Policyholder/Subscriber:	Relationship to Patient:
Policyholder Soc. Security #:	Date of Birth:
Employer Name:	Employer Phone:

Address of Employer:

Insurance Company:	Group #:	Policyholder/Subscriber ID #:
Do you have additional dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Secondary Insurance Information:	

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 in compliance with HIPAA laws.

I authorize and request my insurance company to pay insurance benefits directly to the dentist 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 or my dependents behalf. I understand that any unpaid balance (over 30 days) may be subject to finance charges or billing charges.

Signature:

Date: