Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If student, name of school _____ City _____ State _____ ☐ Full time ☐ Part time

Patient or Parent/Guardian's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's name _____ Employer _____ Work phone _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Email _____ Cell phone _____

Employer _____ Work phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

Ins. Co. address _____ City _____ State _____ Zip _____

Amount of your deductible _____ How much have you used ? _____ Max annual benefit _____

Assignment and Release

I authorize the dentist to release my 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 payors 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. I authorize the use of this signature on all insurance submissions.

X_____

Signature of Patient (or Parent/Guardian, if minor) **Date**