Patient Information

How did you hear about our office?

- ☐ Web:_______________ ☐ Insurance Co. ☐ Advertisement:_______________
- ☐ Referral:_______________ ☐ Saw Sign ☐ Other:_______________

PATIENT INFORMATION:

First Name: Middle Initial:

Last Name: Email:

Mailing Address: Apt/Ste/Unit:

City: State: Zip:

Gender: M or F Single, Partnership, Married, Divorced, Widowed

D.O.B: Age:

Home Phone: ( ) - Work Phone: ( ) -

Cell Phone: ( ) - Emergency Phone: ( ) -

PRIMARY INSURANCE COMPANY Name:

Subscriber First Name: Middle Initial:

Subscriber Last Name:

Gender: M or F Single, Partnership, Married, Divorced, Widowed

Subscriber D.O.B.: Age:

Subscriber S.S.#: Member ID #: Group #:

Employer Name:

Military Rank:

Employer Address:

Relationship to Patient?

SECONDARY INSURANCE COMPANY Name:

Subscriber First Name: Middle Initial:

Subscriber Last Name:

Gender: M or F Single, Partnership, Married, Divorced, Widowed

Subscriber D.O.B.: Age:

Subscriber S.S.#: Member ID #: Group #:

Employer Name:

Employer Address:

Relationship to Patient?

The Insurance co-payment/deductable, which is your responsibility, will be due at time of treatment. Insurance payment from your insurance company is based on their fee schedule, not ours. Sometimes their fees are different giving you a balance due from our office. If this happens we will bill you for that balance.

I (the patient) assume full responsibilty for all dental work performed. The completion of all dental insurance forms is a service, which the dental office offers, however, the final responsibility for collecting from the insurance company is mine. *I assign benefit payment to the above named dental office for treatment performed while a patient at this office.*

Signature: Date: