

# PATIENT INFORMATION

NAME \_\_\_\_\_  MARRIED  SINGLE  MINOR  MALE  FEMALE

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

EMPLOYMENT \_\_\_\_\_ SS# \_\_\_\_\_

NAME OF PARENT OR GUARDIAN,  
IF MINOR \_\_\_\_\_

## INSURANCE INFORMATION

NAME OF SUBSCRIBER \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE /HOME \_\_\_\_\_ WORK \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ DENTAL INS CO. \_\_\_\_\_

SS# \_\_\_\_\_ GROUP # \_\_\_\_\_

MAILING ADDRESS OF INS. CO. \_\_\_\_\_ Phone \_\_\_\_\_

## SECONDARY INSURANCE

NAME OF SUBSCRIBER \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ SR \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE/ HOME \_\_\_\_\_ WORK \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ DENTAL INS CO. \_\_\_\_\_

SS# \_\_\_\_\_ GROUP # \_\_\_\_\_

MAILING ADDRESS OF INSURANCE CO. \_\_\_\_\_ Phone \_\_\_\_\_

Has any member of your family been treated in our office?  Yes  No If so ,

Name \_\_\_\_\_

**Who Referred You to This Office?** \_\_\_\_\_

Payment in full at each appointment (cash, check, credit card) \_\_\_\_\_ ?

If credit card payment Card # \_\_\_\_\_ Exp Date \_\_\_\_\_

I authorize payment of insurance benefits directly to the Dental Office. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic photographic and therapeutic procedures as may be necessary. The information on this page is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Name, Address, Phone \_\_\_\_\_