Patient Information

Name_____ Birthday _____

Address_____

City_____ State_____ Zip Code_____

Marital Status_____ Social Security #_____

Home #_____ Work #_____ Cell #_____

Email address_____Emergency Contact_____

(name and phone number)

Person Responsible for Account_____ DOB_____
Relationship_____

Name of Employer_____
Occupation_____

Address of Employer_____

Name of Primary Person on Insurance_____Primary's Social Security#_____

Address_____

City_____ State_____ Zip Code_____

Primary's Employer_____ Insured DOB_____

Insurance Company_____ Policy #_____ Group # _____

Is the patient covered by another dental plan? (circle one) YES NO

If YES, please fill out the following:

Name of Insured_____ Relationship_____ DOB_____

Name of Employer_____ Insurance Company _____

Policy #_____ Group #_____

How did you hear about our office?_____

I understand that full payment is required for all services rendered on the date of services unless other arrangements are made in advance and that my insurance will be filed for me as a courtesy service. I hereby authorize the dental office to release all information necessary to secure the payment of benefits directly to the office, unless other arrangements have been made. I understand that I am responsible for all charges whether or not they are covered by insurance benefits.

Signature_____ **Date**_____

Your appointment time is reserved for you. Please provide at least **2 business days notice should you need to change your reserved appointment time or a broken appointment fee of **$75** will be charged.***