Patient Information

First _____ MI _____ Last _____

Preferred Name _____ Date of Birth _____

Address_____

City_____ State _____ Zip Code _____

Marital Status _____ Social Security # _____

Employer_____ Occupation _____

Home# _____ Work#_____ Cell#_____

Email address_____

Preferred contact to confirm appointments: _____ Text _____ Email

Emergency contact name _____ Phone _____

How did you hear about our office? _____

Person Responsible for Account_____ DOB_____ Relationship_____

Insurance information

Primary insurance policy holder's name_____ DOB_____

Policy holder's Social Security#_____ Employer_____

Insurance Company _____Subscriber ID# _____ Group#_____

Secondary insurance policy holder's name_____ DOB_____

Policy holder's Social security#_____ Employer_____

Insurance Company _____Subscriber ID# _____ Group#_____

I understand that payment is required for all services rendered on the date of service 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 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 **$50** will be charge.**