Patient Information

Patient Name: _____ Date: _____

Social Security #: _____ Birth Date: _____ Gender: M F Marital Status: S M

Phone Home: _____ Cell Phone: _____ Work: _____

Address: _____
Mailing address Apartment #

_____
City State Zip Code

Employer: _____

Email: _____

Responsible Party Information

(for those under 18 and/or unable to manage)

Name: _____ ☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Phone Home: _____ Work: _____ Ext: _____ Cell phone: _____

Address: _____
Street (if different from patient) Apartment #

_____
City State Zip Code

Employer Name: _____

Dental Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Insurance Plan Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Referral Information

Whom may we thank for referring you to our practice? _____

PLEASE READ CAREFULLY AND SIGN

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service. If I need to discuss finance options, I will do so before treatment begins. I authorize and request my insurance company to pay the dentist directly for insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the billed amount and I am responsible for paying any portion my insurance does not pay. I hereby authorize the dentist to release all information necessary to secure the payment of insurance benefits.

For patients with insurance: We are not in network with any dental insurance. Many insurance companies reimburse the same for in and out of network providers, however some do pay differently. If you are concerned with your coverage, please ask for a pre-determination be done 4 weeks prior to your appointment to allow your insurance enough time to respond. Ask our front desk for more information.

X_____ Date: _____