

PATIENT CONFIDENTIAL INFORMATION



Last Name _____ **First Name** _____ **M.I.** _____

Single Married Divorced Minor Widowed Domestic partner (Circle)

Birth Date: Month _____ Day _____ Year _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Wk _____

Employer _____ **Occupation** _____

If Patient is a minor, Responsible Party _____
Relationship _____

Emergency Contact Name _____ **Phone** _____

I was referred to your office by: _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured _____ **Relationship to Patient** _____

Birth Date: Month _____ Day _____ Year _____ **SSN#** _____

Insured's Employer _____ **Insurance Company** _____

Please show insurance card at the Front Desk OR provide the following:

Insurance Company
Address _____ City _____ State _____ Zip _____

Group Number _____ Insurance Company Phone _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured _____ **Relationship to Patient** _____

Birth Date: Month _____ Day _____ Year _____ **SSN#** _____

Insured's Employer _____ **Insurance Company** _____

YOU ARE FINANCIALLY RESPONSIBLE FOR ANY SERVICES AT THIS OFFICE.

*As a courtesy to our patients we are happy to file your insurance claim. **PLEASE REMEMBER THAT INSURANCE CONTRACT IS BETWEEN YOU AND YOUR INSURANCE CARRIER.***

Assignment & Release: I authorize the dentist or insurance company to release any information required for payment or review of this payment. I authorize payment otherwise payable to me, be paid directly to the dentist.

Signature of Patient or Guardian _____ Date _____