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_____