



## Patient Information

Name:		Date of Birth:	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>	SS#:	
Address:		Home Phone #:	
City:	State:	Zip Code:	Cell Phone #:
Occupation:	Employer:	Work Phone #:	
Date of Last Dental Appointment:		Who may we thank for referring you?	
<b>RESPONSIBLE PARTY</b>			
Person responsible for account:		Address:	
Date of Birth:	Home Phone:	Is this person a patient at our office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupation:	Employer:	Work Phone:	
Is the patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Drivers License #:	
<b>INSURANCE INFORMATION</b>			
<b>Primary Insurance:</b>		Name of Insured:	
Date of Birth:	SS#:	Group #:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
<b>Secondary Insurance:</b>		Name of Insured:	
Date of Birth:	SS#:	Group #:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
<b>FINANCIAL POLICY</b>			
I have read the Bagley Dental PS Financial policy and I agree to abide by their financial policies.			
<b>Initials of Responsible Party</b>			
<b>ADULT AND CHILDREN VISITS</b>			
I have read the Bagley Dental Policies on Adult and Children Visits and I agree to follow their policies and procedures.			
<b>Initials of Responsible Party</b>			
<b>ACKNOWLEDGEMENT OF PRIVACY PRACTICES</b>			
I have read the Bagley Dental PS HIPPA policy and I am aware of the privacy practices required by law.			
<b>Initials of Responsible Party</b>			
<b>IN CASE OF EMERGENCY</b>			
Name of local friend or relative:		Phone #:	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Bagley Dental or insurance company to release any information required to process my claims			
<b>Signature of Responsible Party</b>			<b>Date</b>