Bagley DENTAL

Patient Information

Name:			Date of Birth:
Sex: ☐ M ☐ F	Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐		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?		

RESPONSIBLE PARTY

Person responsible for account:		Address:	
Date of Birth:	Home Phone:	Is this person a patient at our office? ☐ Yes ☐ No	
Occupation:	Employer:	Work Phone:	
Is the patient covered by insurance? ☐ Yes ☐ No		Drivers License #:	

INSURANCE INFORMATION

Primary Insurance:	Name of Insured:	
Date of Birth:	SS#:	Group #:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Secondary Insurance:	Name of Insured:	
Date of Birth:	SS#:	Group #:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other		

FINANCIAL POLICY

I have read the Bagley Dental PS Financial policy and I agree to abide by their financial policies.

Initials of Responsible Party

ADULT AND CHILDREN VISITS

I have read the Bagley Dental Policies on Adult and Children Visits and I agree to follow their policies and procedures.

Initials of Responsible Party

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have read the Bagley Dental PS HIPPA policy and I am aware of the privacy practices required by law.

Initials of Responsible Party

IN CASE OF EMERGENCY

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

Signature of Responsible Party	**Date**