1 PATIENT INFORMATION

NAME:		
ADDRESS:		
CITY:	STATE	ZIP:
PHONE# HOME:	WORK:	EMPLOYER:
BIRTH DATE:	MARRIED ☐	SINGLE ☐
IF PATIENT IF A MINOR, PARENT OR GURDIANS NAME:		
SCHOOL:	GRADE LEVEL:	

2 DENTAL INSURANCE

Primary Coverage

Coverage for: Self ☐ Spouse ☐ Dependants ☐

INSURANCE COMPANY:	
COMPANY ADDRESS:	
INS. PHONE #:	GROUP#:
EMP. SOCIAL SECURITY #:	
PERSON INSURED:	DATE OF BIRTH:
EMPLOYER:	

Secondary Coverage

Coverage for: Self ☐ Spouse ☐ Dependants ☐

INSURANCE COMPANY:	
COMPANY ADDRESS:	
INS. PHONE #:	GROUP#:
EMP. SOCIAL SECURITY #:	
PERSON INSURED:	DATE OF BIRTH:
EMPLOYER:	

3 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:		
ADDRESS:	HOME PHONE#:	
CITY:	STATE:	ZIP:
EMPLOYER:	WORK PHONE#:	SOCIAL SECURITY #:
DATE EMPLOYED:	DRIVERS LICENSE#:	

4 GETTING TO KNOW YOU

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY:	
NAME:	
ADDRESS:	PHONE #:
CITY:	STATE:

IS ANOTHER FAMILY MEMBER OR RELATIVE A PATIENT AT OUR OFFICE? YES ☐ NO ☐ THEIR NAME:
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
YOUR SPOUSE'S NAME:
SPOUSE'S OCCUPATION:
YOUR OCCUPATION:

- I hereby authorize payment directly to the dental office of group insurance benefits otherwise payable to me.
- I understand that I am responsible for all costs of dental treatment performed.
- I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
- I have received a copy of the office's Notice of Privacy Practices.

X ______________________________ **DATE** ______________

PATIENT SIGNATURE (parent or guardian if minor child)