WELCOME

PATIENT INFORMATION

LAST NAME:________________________________ **FIRST:**________________________________ **INITIAL:**________

Date of Birth____________________ Preferred name ____ Sex ☐M ☐F

Address__________________________________City________________________ State_______ Zip ______________

Telephone (Home) ______________________ (Work)_______________________ (Cell)________________________

SS#____________________________________Email____

☐Minor ☐Single ☐Married ☐Widowed ☐Divorced

How did you hear about our practice? ____

INSURANCE INFORMATION - Please present your insurance card(s) to be photocopied for our records.

Primary Insurance_______________________________

Subscriber Name________________________________

Subscriber ID __________________________________

Date of Birth___________________________________

Relationship to Patient ___________________________

Employer Name_________________________________

Insurance Company ______________________________

Insurance Group_________________________________

Insurance Phone________________________________

Secondary Insurance_____________________________

Subscriber Name _________________________________

Subscriber ID____________________________________

Date of Birth____________________________________

Relationship to Patient ____________________________

Employer Name__________________________________

Insurance Company_______________________________

Insurance Group _________________________________

Insurance Phone_________________________________

RESPONSIBLE PARTY (If minor)

Last Name: ________________________________ First: ________________________________Initial: __________

Address (If different) ____ Date of Birth ___________________________

City____ State____________ Zip______________________

Telephone (Home)______________________ (Work)________________________ (Cell)________________________

Email____

EMERGENCY CONTACT

Name: ____Relationship___________________________

Telephone (Home)______________________ (Work)________________________(Cell)________________________

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as necessary for proper dental care. I consent to the release of information concerning my (or my child's) healthcare, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the dentist and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance.

I attest to the accuracy of the information on this page.

Signature____ Date ______________________
(Patient or Responsible Party, if under 18)