WELCOME TO OUR OFFICE

1. About You

Today's Date: ____/____/_____ File #:_____

Patient Name: _____

LAST FIRST MI

What You Prefer To Be Called: _____ Male / Female

Birthdate: ____/____/_____ Age: ____ SS# _____

Mailing Address: _____

City_____ State _____Zip _____

Home Phone #: (_____)_____

Work Phone #: (_____)_____

Cell Phone #: (_____)_____

E-Mail Address: _____

Referred By: _____

Employer: _____How long?_____

Employer's Address: _____

City: _____ State _____Zip _____

Occupation: _____

Status: __Single__Married__Divorced__Separated__Widowed

Spouse's Name: _____

3. Account Information

Person Ultimately Responsible for Account

Name: _____

Relation: _____

Billing Address:_____

City_____State_____Zip_____

SS#: _____

Drivers License #: _____

Work Phone #:(_____)_____

Payment Method: __Cash__Check__Credit Card

Credit Card #_____ ____/____

I hereby authorize assignment of my insurance rights & benefits directly to the provider for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges. Our policy requires payment for all services at the time of visit. If account is not paid within 90 days of date of service, you will be responsible for interest fees, billing charges, collection agency fees, & any other expenses incurred in collecting your account.

Signature:_____Date_____

2. Insurance Information

PRIMARY DENTAL INSURANCE

Company Name:_____

Address:_____

City_____ State _____Zip_____

Phone #:(_____)_____

Insured's ID#/SS#:_____

Group #(Plan, Local, Policy#)_____

Insured's Name:_____

Relation:_____ Date of Birth: ____/___/_____

Insured's Employer:_____

SECONDARY DENTAL INSURANCE

Company Name:_____

Address:_____

City_____ State _____Zip_____

Phone #:(_____)_____

Insured's ID#/SS#:_____

Group #(Plan, Local, Policy#)_____

Insured's Name:_____

Relation:_____ Date of Birth:____/____/_____

Insured's Employer:_____

4. In Event of Emergency

Whom should we contact?_____

Relation:_____

Home Phone #:(_____)_____

Work Phone #:(_____)_____

Cell Phone #:(_____)_____

Who is your Medical Doctor?_____

Medical Doctor's Phone #:(____)_____