

DATE _____ DATE OF BIRTH ___/___/___
PATIENTS NAME _____
IF CHILD, PARENT'S NAME _____
PATIENT/PARENT SS NUMBER _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE: HOME _____ BUS _____
CELL _____
PATIENT/PARENT EMPLOYER _____
PRESENT POSITION _____
SPOUSE/PARENT NAME _____
SPOUSE EMPLOYED BY _____
PRESENT POSITION _____
WHO IS RESPONSIBLE FOR THIS ACCOUNT

HOW DID YOU HEAR ABOUT US _____

PRIMARY DENTAL INSURANCE
COMPANY _____
EMPLOYEE NAME _____
DATE OF BIRTH ___/___/___
SOCIAL SECURITY NO. _____
EMPLOYER _____
NAME OF INS. CO. _____
ADDRESS _____
TELEPHONE _____
UNION LOCAL OR GROUP _____

SECONDARY DENTAL INS.
COMPANY _____
EMPLOYEE NAME _____
DATE OF BIRTH ___/___/___
SSN _____
EMPLOYER _____
NAME OF INS. CO _____
ADDRESS _____
UNION LOCAL OR GROUP _____

MAY WE HAVE YOUR EMAIL ADDRESS?

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement I agreed to be responsible for payment of services not paid, in whole or in part by my dental care payer.

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

PATIENT'S OR GUARDIAN'S SIGNATURE _____