PATIENT INFORMATION (CONFIDENTIAL)

NAME ______________________________ DATE ______________

ADDRESS ______________________ CITY ______________ STATE ______ ZIP ________

EMAIL ______________________ CELL PHONE ____________ HOME PHONE ____________

Please note: Email/text reminders are for appointment purposes ONLY. We respect your privacy and will never sell your information to any third party.

CHECK APPROPRIATE BOX

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

CHECK APPROPRIATE BOX

☐ MALE ☐ FEMALE

SS# ____________ BIRTHDATE __________ DRIVER'S LICENSE # ______________ STATE OF ISSUE ____

EMERGENCY CONTACT ______________________________ PHONE NUMBER ______________

IF COLLEGE STUDENT, FT/PT, NAME OF SCHOOL ____________________ CITY __________ STATE ______

PATIENT OR PARENT'S EMPLOYER ______________________________ WORK PHONE ______________

SPOUSE OR PARENT'S NAME ____________ EMPLOYER ____________ WORK PHONE ______________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ________________ RELATIONSHIP TO PATIENT __________

ADDRESS ______________________________ HOME PHONE ______________

DRIVER'S LICENSE# ______________ BIRTHDATE __________ SS# ______________

EMPLOYER ______________________________ WORK PHONE ______________

INSURANCE INFORMATION

NAME OF INSURED ______________________ RELATIONSHIP TO PATIENT ______________

BIRTHDATE ____________ SS# ______________________ DATE EMPLOYED ______________

NAME OF EMPLOYER ______________________________ WORK PHONE ______________

INSURANCE COMPANY ______________________________ TELEPHONE # ______________

POLICY # ______________________________ GROUP # ______________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO ***IF YES, COMPLETE THE FOLLOWING:***

NAME OF INSURED ______________________ RELATIONSHIP TO PATIENT ______________

BIRTHDATE ____________ SS# ______________________ DATE EMPLOYED ______________

NAME OF EMPLOYER ______________________________ WORK PHONE ______________

INSURANCE COMPANY ______________________________ TELEPHONE # ______________

POLICY # ______________________________ GROUP # ______________

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

X ______________________________ ______________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN, IF MINOR **DATE**