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PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services.
To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, do not hesitate to ask. Thank you.

Patient name: ____ Date of birth: ____________ Sex: ________
Home address: __________________________________ City: _________________ State: _____ Zip______
Billing address (if different): ____
Home phone: ___________________________ Cell: _____________________ Work: __________________
E-mail: __________________________________ Driver's license #:_____________________ State: _____
SS #:_________________________ Spouse's name & phone #:___________________________________
Emergency name and phone #:______________________________________ Relationship _____________
(other than spouse)
Name of your medical doctor: _____________________________________ Date of last visit: ____________
Name of previous dentist: _______________________________________ Date of last visit: _____________
Who may we thank for referring you to us? ____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber's name: ___________________________ Subscriber's DOB: ___________________________
Ins. ID #:___________________________________ Insurance Company: _________________________
Group #:___________________________________

SECONDARY INSURANCE

Subscriber's name: __________________________ Subscriber's DOB: __________________________
Ins. ID#:___________________________________ Insurance Company: ________________________
Group #:__________________________________

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my hygiene treatment, I will be referred to the appropriate dental or medical expert for further evaluation. In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy. I consent to the taking of X-rays before, during and after treatment. I also consent to the use of same by the doctor in scientific papers or demonstrations. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved and do consent to dental treatment.
I have read the above.

Signature: ____________________________________ Date: ____________________