# PATIENT INFORMATION

**General Information:** Date: _____

Mr. Dr.

Mrs. Miss Ms. Name: _____

Last First M

Preferred name/nickname: _____ Gender: ☐ Male ☐ Female

Address: _____ _____

Street Apt # City State Zip

Birthdate: _____ SSN: _____

Telephone: _____ _____ _____

Home Work Cell

If child, parents' names: _____

E-mail Address: _____ Occupation: _____

Employer: _____

Employer Address: _____

Street City State Zip

Person to contact in case of emergency:

Name: _____ Telephone: _____

Chief complaint for today's visit: _____

_____

Whom may we thank for referring you to our office? _____

**Insurance:**

*Please provide copy of your insurance card*

Primary insured's name if other than patient: _____

Insurance Company: _____ Insurance Telephone: _____

Date of Birth of Primary: _____ SSN: _____

I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the dentist. I understand that I am responsible for all dental fees. I understand that I will be charged for all dental treatment and payments received by the dental office from my insurance carrier will be credited to my account or refunded to me if I have paid the dental fees incurred.

In the event legal action is required to collect any unpaid balance, I will be obligated to pay: court costs, attorney fees, interest, and costs of collection.

I hereby authorize payment directly to the dental office of the group insurance otherwise payable to me.

## CERTIFICATION

I agree to the above and certify the information on this page is correct to the best of my knowledge.

Signature: _____ Date: _____