Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Gender: M☐ F☐ Marital Status: S☑ M☐

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Address: _____
Mailing address Apartment #

_____
City State Zip Code

Employer: _____

Email: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment—relationship _____

Name: _____ ☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell phone: _____

Address: _____
Street (if different from patient) Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Insurance Plan Name and Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Insurance Plan Name and Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Consent for Payment of Services

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service. If I need to discuss finance options, I will do so before treatment begins. For patients with insurance: I authorize and request my insurance company to pay the dentist directly for insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the billed amount and I am responsible for paying any portion my insurance does not pay. I hereby authorize the dentist to release all information necessary to secure the payment of insurance benefits.

_____ Date: _____ Relationship to Patient: _____