

Patient Information:

First Name _____ Last Name _____ Middle Initial _____
 Preferred Name _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 E-mail _____ Preferred Contact _____
 Sex _____ Age _____ Marital Status _____ Birth date _____
 Social Security # _____ Driver's License # _____
 Employer _____ Occupation _____ How long employed _____
 May we call you at work? _____
 Who may we thank for referring you? _____

Responsible Party (if someone other than patient):

First Name _____ Last Name _____ Middle Initial _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 E-mail _____ Preferred Contact _____
 Sex _____ Age _____ Marital Status _____ Birth date _____
 Social Security # _____ Driver's License # _____
 Employer _____ Occupation _____ How long employed _____
 May we call you at work? _____

Primary Insurance:

Name of Insured _____ Birthdate _____
 Relationship to Patient _____
 Address (if different from patient) _____
 Dental Insurance Co. _____ Phone _____
 Social Security # _____ Subscriber ID # _____
 Group # _____

Insurance Payments:

In order to file your insurance, we now ask for a credit card on file. It is impossible to estimate your coverage exactly. When we receive your insurance payment, we can bill your card for any remaining balance or credit your card immediately if you have over paid.

CIRCLE ONE: Visa MasterCard Discover Amex
 Account # _____ Expiration Date _____
 Name on card _____

In Case of Emergency:

Name and phone number of primary care physician

 Someone we may contact _____ Phone _____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card for any unpaid balances, including those after insurance payment. I further authorize this office to charge my credit card to cover any unpaid fees not paid by insurance after 60 days. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge.

Signature _____ Date _____