

# WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can assist you with your dental needs.

## PATIENT INFORMATION :

Today's Date \_\_\_\_\_ Birth Date \_\_\_\_\_ Patient Social Security # \_\_\_\_\_  
Patient Name \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Patient Home Phone \_\_\_\_\_ Patient Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email Address \_\_\_\_\_  
Occupation \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced  Separated  
Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Employer Address \_\_\_\_\_

## IN CASE OF EMERGENCY CONTACT:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Emergency Home Phone \_\_\_\_\_ Emergency work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## PRIMARY DENTAL INSURANCE:

Individual responsible for this account \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)  
Relationship to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Responsible Party Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Insurance Address \_\_\_\_\_  
Subscriber I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

## ADDITIONAL DENTAL INSURANCE:

Insured Individual's Name \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)  
Relationship to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Responsible Party Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Insurance Address \_\_\_\_\_  
Subscriber I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

## ASSIGNMENT AND RELEASE:

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**