PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex ❒ M ❒ F Age _____ Date of Birth ___/___/___ ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Patient Employed by _____ Occupation _____

Work Address _____

Work Phone _____ Cell Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Date of Birth ___/___/___ Soc. Sec. # _____

Address *(if different from patient's)* _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Work Address _____

Work Phone _____ Cell Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❒ Yes ❒ No

Subscriber Name _____ Relation to Patient _____ Date of Birth ___/___/___

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Work Phone _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

METHOD OF PAYMENT

Which of the following methods of payment will you be using? ❒ Cash ❒ Check ❒ VISA ❒ MC ❒ Discover
(Fees must be paid in full at the completion of treatment.)

All information written is true and complete. SIGNATURE _____ DATE: _____

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment amount of payment, any difference of payment is entirely the responsibility of the patient. INITIALS _____

Updates (date & initial) _____ _____ _____ _____ _____

CONFIDENTIAL (for record and evaluation)