WELCOME TO TOOTH BY THE LAKE

PATIENT INFORMATION

Patient Name _____
Last First Middle

I prefer to be called_____ Male_____ Female____

Birthdate_____Age____SS#_____

Single ___ Married ___ Divorced ___ Widowed ___ Other __

IF CHILD PLEASE GIVE PARENT INFORMATION

Name_____
Last First Middle

'Birthdate_____Age_____

Street Address_____

City_____ State_____ Zip Code_____

Patient/Parent Employed By_____

Spouse's Name_____

Spouse Employed By_____

Who Is Responsible For This Account?_____

Purpose Of Visit_____

Other Family Members in This Practice_____

Whom May We Thank For This Referral?_____

PHONE NUMBERS

Home_____ Work_____

Cell Phone_____ Spouse's Cell_____

E-mail_____

Best time/place to reach you_____

Emergency Contact Not Living With You:

Name_____

Phone Number_____

Relationship_____

DENTAL INSURANCE Primary Coverage

Insurance Company_____

Insurance Company Address_____

City_____ State_____Zip_____

Insurance Company Phone #_____

Group # (Plan or Policy)_____

Subscriber ID #_____

Insured's Name_____Relation_____

Insured's Birthdate_____

Insured's Employer_____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits

I understand I am financially responsible for payment in full of all accounts. I understand that my dental care insurance carrier or payer of dental benefits may pay less than the actual bill for services and I am responsible for the balance at time of service. By signing this statement I revoke all previous agreements to the contrary and agree to pay for services when they are provided.

Patient or Guardian's Signature_____Date_____