PATIENT INFORMATION

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City, State, Zip: _____ Work Phone: _____

Birthday: _____ Employer: _____

Social Security No.: _____ Address: _____

Referral: _____ Occupation: _____

Previous Dentist: _____ Phone No.: _____

Physician: _____ Phone No.: _____

Emergency Contact: _____ Phone No.: _____

Insurance Carrier: _____

Address: _____

ID # _____

Group # _____

Person responsible for Account: _____

Relation to patient: _____

Authorizations:

I certify that my minor/child or myself is covered by insurance with

_____ (name of insurance company) and assign directly to Dr. Ridlen all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Date: _____ _____

Signature of patient/guardian