PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____

ADDRESS_____CITY_____STATE_____ZIP_____

EMAIL _____ CELL PHONE _____ HOME PHONE _____

Would you like to receive correspondence via email? ☐YES ☐NO Would you like to receive correspondence via text? ☐YES ☐NO

DRIVER'S LICENSE # _____STATE OF ISSUE _____

SS#_____BIRTHDATE _____ ☐MALE ☐FEMALE

CHECK APPROPRIATE BOX ☐MINOR ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED

IF COLLEGE STUDENT, FT/PT, NAME OF SCHOOL_____CITY _____STATE_____

PATIENT OR PARENT'S EMPLOYER_____WORK PHONE_____

SPOUSE OR PARENT'S NAME_____EMPLOYER_____WORK PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____

ADDRESS _____HOME PHONE _____

DRIVER'S LICENSE# _____BIRTHDATE_____SS# _____

EMPLOYER _____WORK PHONE _____

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____DATE EMPLOYED _____

NAME OF EMPLOYER _____WORK PHONE _____

INSURANCE COMPANY_____ TELEPHONE # _____

POLICY # _____ GROUP # _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐YES ☐ NO ***IF YES, COMPLETE THE FOLLOWING:***

NAME OF INSURED _____RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY_____ TELEPHONE #_____

POLICY # _____ GROUP # _____

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to this dental office 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 authorize the use of my signature on all insurance submissions.

X_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN, IF MINOR **DATE**

PRINT FORM