PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ BIRTHDATE_____ TODAY'S DATE _____

ADDRESS_____CITY_____STATE_____ZIP_____

EMAIL _____ CELL PHONE _____ HOME PHONE _____

Please note: Email/text reminders are for appointment purposes ONLY. We respect your privacy and will never sell your information to any third party.

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

CHECK APPROPRIATE BOX ☐ MALE ☐ FEMALE

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

PATIENT/PARENT'S EMPLOYER_____OCCUPATION_____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 _____

BIRTHDATE_____

EMPLOYER _____WORK PHONE _____

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ 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 _____ 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**