

# PATIENT INFORMATION



## Patient

|                                  |              |                      |                            |                   |  |   |
|----------------------------------|--------------|----------------------|----------------------------|-------------------|--|---|
| <i>Last Name</i>                 |              | <i>First</i>         |                            | <i>MI</i>         | <i>Male</i> <input type="checkbox"/>   | <i>Married</i> <input type="checkbox"/> |
| <i>Preferred Name (Nickname)</i> |              | <i>Birthdate</i> - - |                            | <i>SS#</i> - - -  | <i>Female</i> <input type="checkbox"/> | <i>Single</i> <input type="checkbox"/>  |
| <i>Address</i>                   |              | <i>Apt #</i>         | <i>Home Phone</i><br>( ) - |                   | <i>Cell Phone</i><br>( ) -             |   |
| <i>City</i>                      | <i>State</i> |                      | <i>Zip</i>                 | <i>Home email</i> |  |   |

## Employer

|                |              |                |  |
|----------------|--------------|----------------|--|
| <i>Name</i>    |              |                |  |
| <i>Address</i> |              | <i>Suite #</i> | <i>Work Phone</i><br>( ) - <i>Ext.</i> |
| <i>City</i>    | <i>State</i> | <i>Zip</i>     | <i>Work email</i>                      |

## Insurance

|                          |              |                      |                                   |
|--------------------------|--------------|----------------------|-----------------------------------|
| <i>Subscriber's Name</i> |              | <i>Birthdate</i> - - | <i>SS#</i> - - -                  |
| <i>Carrier Name</i>      |              |                      |                                   |
| <i>Address (PO Box)</i>  |              | <i>Suite #</i>       | <i>Phone</i><br>( ) - <i>Ext.</i> |
| <i>City</i>              | <i>State</i> | <i>Zip</i>           | <i>Website</i>                    |

If you have dental insurance, we will gladly assist you in the processing of your claims to maximize the benefits to which you are entitled. HOWEVER, your insurer has a contract between your employer and you, not the dentist, so **you are responsible for all charges** incurred.

## Parent Information (if patient is a minor.)

**\*NOTE:** We are required to have on file below the parent who brings the child in for care.

|                         |              |              |                            |  |   |  |
|-------------------------|--------------|--------------|----------------------------|--|---|--|
| <i>Last Name</i>        |              | <i>First</i> |                            | <i>MI</i>                              | <i>Married</i> <input type="checkbox"/> | <i>Single</i> <input type="checkbox"/> |
| <i>Address</i>          |              | <i>Apt #</i> |                            | <i>Birthdate</i> - -                   | <i>SS#</i> - - -                        |  |
| <i>City</i>             | <i>State</i> | <i>Zip</i>   | <i>Home Phone</i><br>( ) - |  |   |  |
| <i>Employer</i>         |              |              |                            |  |   |  |
| <i>Employer Address</i> |              |              | <i>Suite #</i>             | <i>Work Phone</i><br>( ) - <i>Ext.</i> |   |  |
| <i>City</i>             | <i>State</i> | <i>Zip</i>   | <i>Work email</i>          |  |   |  |

## Signature

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
| <i>How did you hear about our office?</i>  |  |  |  |  |  |  |
| <i>Today's payment will be by:</i> <i>Cash</i> <input type="checkbox"/> <i>Check</i> <input type="checkbox"/> <i>Visa</i> <input type="checkbox"/> <i>M/C</i> <input type="checkbox"/> <i>Discover</i> <input type="checkbox"/> <i>AmEx</i> <input type="checkbox"/> |  |  |  |  |  |  |

By signing below, I certify that all of the above statements are true to the best of my knowledge, that I understand I am responsible for all charges incurred (regardless of any insurance coverage,) and I agree to pay all collection costs associated with late or non-payment of this account:

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(If patient is a minor, only the parent bringing the child in for care may sign)