

PATIENT INFORMATION AND HEALTH HISTORY

DATE: _____

PATIENT NAME: _____
SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPERATED WIDOWED

DATE OF BIRTH: _____ SS#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ BUSINESS PHONE: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____

REFERRED BY: _____

DENTAL INSURANCE

PRIMARY

SECONDARY

INSURANCE CO: _____

GROUP #: _____

EMPLOYER: _____

INSURED:

LAST NAME: _____

FIRST NAME: _____

SS# OR ID #: _____

DATE OF BIRTH: _____

RELATIONSHIP: _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date: _____

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