



DARROW

FAMILY DENTAL CENTRE

ABOUT YOU

Date _____

Patients's First Name _____

Last Name _____

Preferred Name _____

Address _____

Marital Status _____

Spouse/Parent's Name _____

Home Phone _____

Work Phone _____

Cell Phone _____

Birth date _____

SS# _____

E-Mail _____

Referred By _____

Employer Name _____

Occupation _____

Insurance Information

Primary Insurance _____

Address _____

Insured's Name _____

SS# _____

Employer _____

Group # _____

Relation to Patient _____

Insured's Date of Birth _____

Secondary Insurance _____

Address _____

City _____ State _____

Zip _____

Who Do We Contact in Case of Emergency _____

Phone # _____

Responsible Party for Account (if different from patient)

- ❖ We invite you to discuss with us any questions regarding our services
- ❖ Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with the business manager.
- ❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ❖ I am aware of Notice of Privacy Practices on File

Signature _____ Date _____