

# WELCOME

In order for us to better serve you, please fill in the information completely.

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

(last name) (first name) (initial)

Patient Social Security # \_\_\_\_\_ Occupation \_\_\_\_\_

Driver's License # \_\_\_\_\_

If patient is a student: Name of school \_\_\_\_\_

Parent's Social Security # \_\_\_\_\_

Age \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female

Single  Married  Widowed  Divorced  Separated

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's Employer Address \_\_\_\_\_

### In Case of Emergency Contact

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Former Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Reason for this Appointment \_\_\_\_\_

## DENTAL INSURANCE

Individual responsible for this account

(last name) (first name) (initial)

Relationship to Patient \_\_\_\_\_

DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Responsible party employed by \_\_\_\_\_

Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

## ADDITIONAL INSURANCE

Insured Individual's Name:

(last name) (first name) (initial)

Relationship to Patient \_\_\_\_\_

DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Insured Party Employed by \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I authorize my Insurance Company to pay to the dentist or dental group, all insurance benefits 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 \_\_\_\_\_

### PAYMENT IS DUE IN FULL AT TIME OF TREATMENT.

Information you give is confidential and will not be released to anyone without your written permission.

For your benefit, a thorough examination, usually including dental x-rays and diagnostic models of your mouth, is necessary before intelligent and efficient analysis of your oral conditions can be made.

After thorough diagnosis, your dental conditions can be discussed intelligently, treatment can be planned, and your investment in this health plan understood and arranged.

It is a pleasure to serve your dental needs and to discuss these conditions with you. Should you choose to place the care of your dental health with us, please be assured the most thorough, conscientious service will be dedicated to this trust. All facilities and personnel of this office are expressly here to serve you and your health.