



PATIENT INFORMATION (Confidential)

Patient's Name: \_\_\_\_\_ Sex:  Male  Female
Status:  Minor or Student  Single  Married  Divorced  Widowed
Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec. #: \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
E-mail: \_\_\_\_\_ I would like to receive correspondence via e-mail  Yes  No
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_
Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ May we contact you at work?  Yes  No
Spouse/Parent's Name: \_\_\_\_\_
Spouse/Parent's Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_
Person to Contact in Case of Emergency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_
Whom may we thank for referring you to our office? \_\_\_\_\_

RESPONSIBLE PARTY (if other than patient)

Person Responsible on Account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_
Social Sec. #: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

For your convenience, we offer the following methods of payment. Please check the option you prefer. Copayments are expected at each appointment.  Cash  Check  Credit/Debit Card (Mastercard, Visa, Discover or American Express)  Financing (thru Capital One)

INSURANCE INFORMATION

Dental Insurance Company: \_\_\_\_\_ Policy No./SS#: \_\_\_\_\_ Group No: \_\_\_\_\_
Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_
Insured's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

DO YOU HAVE A SECONDARY DENTAL INSURANCE?  Yes  No (IF "YES", COMPLETE THE FOLLOWING.)

Secondary Dental Insurance Co: \_\_\_\_\_ Policy No./SS#: \_\_\_\_\_ Group No: \_\_\_\_\_
Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_
Insured's Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due in full when services are rendered. I understand this office is not a provider of my insurance and insurance may pay less than the actual bill of services. I authorize this office to bill my insurance and send any information needed to process my dental claim by mail, fax and/or by e-mail.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship (if signed by authorized agent of Patient): \_\_\_\_\_