COMPLETION OF THIS FORM IN ITS ENTIRETY IS REQUIRED AT TIME OF VISIT/TREATMENT

Patient Information

Name: _____ Social Security # ____ - ___ - _____
LAST FIRST M.I.

Date of Birth: _____ Age: _____ Email Address: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ H: ☐ C: ☐ W: ☐

Employed by: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent Name: _____ Social Security #: _____ - _____ - _____ DOB: _____

Employer: _____ Occupation: _____ Phone: (_____) _____

In Case of Emergency:

Contact Other than spouse/parent: _____ Phone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____

Who referred you to our practice? _____

Dental Insurance

Subscriber Name: _____ Social Security # _____ - _____ - _____

Insurance Co: _____ Insurance Phone: (_____) _____

Employer: _____

Secondary Insurance Information: ***If you have NO insurance, check here:*** ☐

Subscriber Name: _____ Social Security # _____ - _____ - _____ DOB: _____
Insurance Co: _____ Insurance Phone: (____) _____
Employer: _____

If someone other than the patient is responsible for payment, complete the following:

Name: _____ Social Security #: ____ - ____ - ____ Phone: (____) _____
Relationship to Patient: _____
Address: _____ City: ____ State: ____ Zip: ____

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information for this claim. I authorize that the doctor can use my records if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms policy.
I consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the use of information by the doctor in scientific papers or demonstrations for educational purposes.
I certifiy that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature: _____ **Date:** _____