Patient Information Form
(please complete & return to receptionist)

NAME: Last, First, Middle	☐ Male ☐ Female	TODAY'S DATE

ADDRESS: Street or PO Box	City	State	Zip

PHONE NUMBERS: Home	Cellular	Pager	Fax

AGE	BIRTH DATE	BIRTH PLACE	☐ Single ☐ Married ☐ Divorced/Separated	SOCIAL SECURITY NO.

OCCUPATION	EMPLOYER	HOW LONG EMPLOYED	PHONE NUMBER

SPOUSE OR PARENT	BIRTH DATE	ADDRESS

RELATIONSHIP	SOCIAL SECURITY NO.	EMAIL

OCCUPATION	EMPLOYER	HOW LONG EMPLOYED	PHONE NUMBER

Insurance Information

INSURED PERSON'S FULL NAME	DATE OF BIRTH

SOCIAL SECURITY NO.	RELATIONSHIP TO PATIENT	WORK PHONE

INSURANCE COMPANY NAME	GROUP OR UNION NAME	GROUP, LOCAL NO., OR PLAN NO.

EMPLOYER'S NAME	FULL ADDRESS OF INSURANCE COMPANY

DO YOU HAVE OTHER DENTAL INSURANCE

Getting To Know You

1) Why did you select our office? ______________________________

2) Whom may we thank for referring you? ______________________________

3) Is there another member of your family or relative a patient in our practice? ______________________________

4) Person to contact in case of emergency: ______________________________

Relationship: ______________________________

Phone: ______________________________

Payment Alternatives

If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage your particular plan provides. We accept assignment of your insurance payment, another service to you. This means that you are responsible for your deductible and the portion that your insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us. For more information on insurance, please contact us.

For All Patients

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminder items sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office.

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

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