PATIENT INFORMATION

Date:_____

Name_____ Soc. Sec. #_____
Last Name First Name Initial

Address_____ Home Ph._____

City_____ State_____ Zip_____

Sex o M o F Age _____ Birthdate_____ o Single o Married o Widowed o Separated o Divorced

Patient Employed by_____ Occupation _____

Work Address_____ Work Ph._____ Cell Phone_____

Who may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone_____

Emergency Contact relation to patient: _____

If Self-Pay check box and skip down to MOP ☐

Primary Dental Insurance

Subscriber: _____
Last Name First Name Initial

Relation to Patient_____ Birthdate_____ Soc. Sec.#_____

Address (if different from patient's) _____ Phone_____

City_____ State_____ Zip_____

Subscriber Employed by (or Ins. Group Name) _____ Occupation_____

Bus. Address _____ Bus. Ph._____ Cell. Ph._____

Insurance Company _____

Phone # _____ Group# _____ Subscriber/ID # _____

Additional Dental Insurance

Is patient covered by additional insurance? o Yes o No

Subscriber Name_____ Relationship to Patient_____ Birthdate_____

Address (if different from patient's) _____ Phone_____

City _____ State_____ Zip_____

Subscriber Employed by _____ Bus. Ph. _____

Insurance Co. _____ Soc. Sec. # _____

Phone# _____ Group# _____ Subscriber/ID # _____

Names of other dependenets covered under this plan_____

Method of Payment (MOP)

Which of the following methods of payment will you be using? (Fees must be paid in full at the completion of treatment.)
Method of Payment: (please check) o Cash o Check o VISA o MC o Discover o Care Credit

All information written is true and complete: Signature_____ **Date:** _____
(Signature of Patient or Person Responsible for Account)

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. **Initials:** _____

Updates (date & initial) _____ _____ _____ _____ _____