WELCOME
TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your dental care needs.

PATIENT INFORMATION

Today's Date ____________ Birth Date ____________ Patient Social Security # ____________

Patient Name ____________ (Last Name) (First Name) (Initial)

Street Address ____________

City ____________ State ____________ Zip ____________

Occupation ____________ ❒ Male ❒ Female ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Separated

Patient Home Phone ____________ Patient Work Phone ____________

Employer ____________ Employer Phone ____________

Employer Address ____________

In Case Of Emergency Contact:

Name ____________ Relationship ____________

Emergency Home Phone ____________ Emergency Work Phone ____________

Whom may we thank for referring you to us? ____________

PRIMARY INSURANCE

Individual responsible for this account ____________ (Last Name) (First Name) (Initial)

Relationship to Patient ____________ Birth Date ____________ Social Security # ____________

Street Address ____________ Home Phone ____________

City ____________ State ____________ Zip ____________

Responsible Party Employed By ____________ Business Phone ____________

Business Address ____________ Occupation ____________

Insurance Company ____________

Insurance Company Address ____________

Subscriber I.D. # ____________ Group # ____________

ADDITIONAL INSURANCE

Insured Individual's Name ____________ (Last Name) (First Name) (Initial)

Relationship to Patient ____________ Birth Date ____________ Social Security # ____________

Street Address ____________ Home Phone ____________

City ____________ State ____________ Zip ____________

Insured Party Employed By ____________ Business Phone ____________

Insurance Company ____________

Insurance Company Address ____________

Subscriber I.D. # ____________ Group # ____________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________ and assign directly to Dr. ____________ all insurance benefits, for any services provided me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original. In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here. I expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each nd every claim submitted.

Signature ____________ Date ____________