PATIENT INFORMATION

NAME: _____ DOB: _____ S.S.#: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: _____ HOW WOULD LIKE TO CONTACTED? TEXT / EMAIL / PHONE

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

RESPONSIBLE PARTY'S NAME: _____ PHONE #: _____

DOB: _____ S.S. #: _____ RELATIONSHIP to Patient: _____

ADDRESS: _____ CITY: _____ ZIP: _____

EMPLOYED BY: _____ PHONE #: _____

EMPLOYER ADDRESS: _____ PHONE: _____

NAME of DENTAL INSURANCE: _____ PHONE: _____

ADDRESS: _____ GROUP #: _____

POLICY HOLDER'S NAME: _____DOB: _____S.S.#: _____

NAME of SECONDARY INSURANCE: _____PHONE #: _____

ADDRESS: _____ GROUP #: _____

POLICY HOLDER'S NAME: _____DOB: _____S.S.#: _____

Who May We Contact In Case of an Emergency? NAME: _____

RELATIONSHIP to Patient: _____ PHONE #: _____

I HEREBY AUTHORIZE payment directly to the doctor of benefits due me for his services as described. I understand I am financially responsible for charges not covered by this authorization. I also authorize the release of any medical information relating to this claim, and if my account should become delinquent of more than 90 days an interest fee of 1% per month will incur to my account.

SIGNATURE of PATIENT, INSURED or GUARDIAN: _____

Date: _____