



Patient Information

Please Print

Circle One: Dr/Mr/Mrs/Ms/Miss

First: _____ Middle: _____ Last: _____ Jr/Sr: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email Address: _____ May we contact you by email? (circle) **Yes No**

Patient Social Security Number: _____ Patient Date of Birth: _____ Sex: (circle) **M F**

Emergency Contact: _____ Phone: _____

Preferred Pharmacy _____

How did you hear about us?

Newspaper Radio TV Internet Referral Other: _____

Insurance Information

Do you have Dental Insurance? (circle) **Yes No** Do you have Secondary Dental Insurance? (circle) **Yes No**

Primary Insured		Secondary Insured	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship to Subscriber	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

Please present your insurance card to our patient services representative to be photocopied

Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance).

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature _____ Date _____

Responsible Party (If patient is under 18 or disabled)

Circle One: Dr/Mr/Mrs/Ms/Miss

First: _____ Middle: _____ Last: _____ Jr/Sr: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Patient SSN: _____ - _____ - _____ Patient Date of Birth: ____/____/____ Sex: (circle) **M F**

Signature: _____ Date: _____