PATIENT INFORMATION

Patient Name_____Preferred name_____ Birthdate_____

Sex____Marital Status_____SSN (required unless total fee paid in full at each visit)_____

Home address_____

City/State_____Zip_____Home phone_____

Employer_____Occupation_____Work phone_____

Email address_____ Cell Phone_____

Preferred method of contact: Home phone _____ Email _____ Cell phone _____

Whom may we thank for this referral?_____

Emergency Contact_____relationship_____phone #_____

Person Responsible for Payment (if not same as above) - Please note: we cannot bill a non-custodial parent
Name_____Relationship_____

Birthdate_____ SSN (required unless total fee paid in full at each visit)_____

Billing Address_____

City/State_____Zip_____Home phone_____

Employer_____Occupation_____Work phone_____

Email address_____ Cell Phone_____

Insurance	**Primary**	**Secondary**
Insurance Co. Name		
Billing Address		
Telephone		
Group #		
Policyholder's name		
Policyholders ID #		
Relationship to Patient		
Policyholder's Birthdate		
Policyholder's Employer		

I hereby authorize the dentist to furnish information to insurance carriers concerning my dental condition and treatments and I hereby assign to them all payments for dental services to myself or my dependents. I understand that I am responsible for all fees regardless of insurance coverage.

Policyholder Signature _____ Date _____
Policyholder Signature _____ Date _____