Patient Name _____ Nickname_____ Date_____
First Last Middle Initial

Date of birth_____ E-mail_____

Home Phone _____ Cell Phone_____ Work Phone_____

Address_____
Street address City State Zip

Occupation_____ Employer/School Address_____
Street Address City State Zip

How did you hear about our office?_____

Who may we thank for referring you to our office?_____

Person to contact in case of emergency,

Name_____ Cell phone_____

Relationship to patient _____Home phone_____

Person Responsible For Account, If not patient

Name_____ Relationship to patient_____

Mailing Address_____

Home phone_____ Cell phone_____

Dental Insurance

Subscriber name_____ Date of birth_____

Employer_____ SS#_____

Insurance Co._____ Address_____

Group # _____ ID #_____

Relationship to Patient Self___ Spouse___ Child___

Secondary Insurance

Subscriber name_____ Date of birth_____

Employer_____ SS#_____

Insurance Co._____ Address_____

Group # _____ ID #_____

Relationship to Patient Self___ Spouse___ Child___

Assignment and Release: I authorize the use of my signature and identifying information to process insurance claims. I also authorize my insurance benefits to be paid directly to the dentist. I understand I am financially responsible for any balances due.

Signature_____ Date_____