PATIENT INFORMATION

Patient's Name: _____

Date of Birth: _____ Single Married Divorced Widowed

Address: _____

City: _____ State: _____ Zip: _____

Home Ph.#: _____ Cell Ph.#: _____ E-mail: _____

Patient Employed By: _____ Position: _____

Business Address: _____ Business Ph #: _____

Patient Social Security #: _____

If patient is minor, give parents name: _____

If patient is full time student, name & city of school: _____

Whom may we thank for this referral: _____

Spouse Name: _____

Spouse employed by: _____

Someone to notify in case of emergency

Not living with you: _____ Phone #: _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's SSN: _____

Insured's place of employment: _____

Insurance Company: _____ Group #: _____

Insured's date of birth: _____ Union/Local #: _____

Do you have dual coverage? ❒ Yes ❒ No

Insured's Name: _____ Insured's SSN: _____

Insured's place of employment: _____

Insurance Company: _____ Group #: _____

Insured's date of birth: _____ UnionI/Local #: _____

CONSENT:

I understand that I am responsible for payment for dental services provided for myself or my dependents at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½% finance charge (18% APR) will be added to my account. If necessary, I hereby authorize this office to obtain credit bureau reports.

Patient Name: _____ Date: _____