PATIENT INFORMATION FORM

Name_____

(First) (Middle) (Last) (Nickname)

Home Address_____

City_____ State_____ Zip_____

Home Telephone No._____ Work Telephone No._____

Cell Phone No._____ E-Mail Address_____

Social Security #_____ Employer _____

Age_____ Birth Date _____ Male ☐ Female ☐ Height_____Weight_____

Single ☐ Married ☐ Divorced ☐ Widow ☐ Referred By_____

In case of emergency, who may we contact?

His/her Name_____ Relationship_____

Home Telephone No._____ Work Telephone_____

Person responsible for this account if other than yourself

His/her Name_____ Relationship_____

Billing Address_____

Home Telephone No._____ Work Telephone No._____

Employer_____ Social Security No._____

Dental Insurance Information

Primary Dental Insurance:

Insured's Name_____ Relationship_____

Address_____ Telephone No._____

Insurance Co. Name_____ Group No._____

Insured's Social Security or ID # _____

Insured's Date of Birth_____ Insured's Employer_____

Secondary Dental Insurance:

Insured's Name_____ Relationship_____

Address_____ Telephone No._____

Insurance Co. Name_____ Group No._____

Insured's Social Security or ID #_____

Insured's Date of Birth_____ Insured's Employer_____

I hereby authorize release of any information and records of treatment to my insurance company. I hereby authorize payment directly to the dental office for any services rendered.

I accept responsibility for payment of all charges. I understand that should my account become delinquent and is referred to an attorney for collection, I will be responsible for all costs of collection and attorney's fees of 33-1/3% of the unpaid balance at the time of referral. I accept incurring a $5.00 rebilling fee for each month my account remains unpaid for 90 days or over.