PATIENT INFORMATION

Date: _____

Name: _____ Pronunciation: _____

Preferred Name: _____ Marital Status: __ Single __ Married __ Other

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

SS#: _____ Driver's License#: _____ Date of Birth: _____ Age: _____

Occupation: _____ Employer: _____ Business Phone: _____

Spouse's Name: _____ Spouse's SS# _____

Spouse's Occupation _____ Employer: _____ Bus Phone: _____

Person to contact in case of emergency: _____ Relationship: _____

Home Phone: _____ Cell: _____ Business: _____

Party Responsible for Payment of Account _____

Whom may we thank for referring you? _____

Appointment Confirmation Preference: ___ Home Phone ___ Cell Phone ___ Business Phone ___ E-Mail

Dental Insurance Carrier: _____ Subscriber: _____Self___Spouse___Child___

Subscribers DOB _____ SS# or ID# _____Employer: _____

Group #: _____ Insurance Address: _____ Insurance Phone #: _____

A NOTE TO OUR DENTAL INSURED PATIENTS

We are delighted you have dental insurance and we will do our best in assisting you to secure the maximum dental benefits allowed under your individual policy. Although we do not accept assignment of benefits from your insurance company, we are excited and pleased to offer the service of *Electronic Claim Submission* to your primary carrier. Please present your insurance information card at your first visit. **Your full payment for services rendered is required at the time of your visit, unless a specific financial agreement has been authorized.**

_____ _____

Patient Signature **Date**