WELCOME TO OUR PRACTICE

DATE:

PATIENT INFORMATION

Patient Name: _____ (Last Name) _____ (First name) _____ (Initial)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone: _____ Work phone: _____ Cell phone: _____

Whom can we thank for referring you? _____

Sex: ____ M ____ F Birthdate: _____ School Name/City: _____

Employer: _____ Occupation: _____

Name of nearest relative in case of emergency: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: _____ (Last Name) _____ (First Name) _____ (Initial)

RP. Address, *if different than patient:* _____ (Street) _____ (City) _____ (State) _____ (Zip)

RP. Phone, *if different than patient:* _____

Relationship to patient: _____

PRIMARY DENTAL INSURANCE

Subscriber Name: _____

Address: _____

ID#: _____ SS#: _____

Subscriber B'day: _____

Relationship to pt: _____

Employer: _____

Employer Phone: _____

Insurance Name: _____

Group #: _____ Local #: _____

Group Name: _____

SECONDARY DENTAL INSURANCE

Subscriber Name: _____

Address: _____

ID#: _____ SS#: _____

Subscriber B'day: _____

Relationship to pt: _____

Employer: _____

Employer Phone: _____

Insurance Name: _____

Group #: _____ Local #: _____

Group Name: _____

I authorize release of any information related to my claims. I understand I am responsible for all costs of dental treatment. I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me.

Signature _____ Date: _____