PATIENT INFORMATION SHEET

DATE: ____________________

NAME: Last ____________________ First ____________________ Middle Int. __________

ADDRESS: Street ______________________________ P.O. Box # ____________________

City ____________________ County ____________ State __________ Zip Code __________

TELEPHONE: Home ____________________ Work ____________________ Cell ____________________

PATIENT DATE OF BIRTH: ____________________ SOCIAL SECURITY #: ____________________

PATIENT EMPLOYED BY: ____

REFERRED BY: Dentist Name ____________________ Friend ____________________

PERSON TO CONTACT IN CASE OF EMERGENCY: ____________________

ADDRESS: Street ____

City ____________________ State __________ Zip Code __________

TELEPHONE: ____________________ RELATIONSHIP: ____________________

RESPONSIBLE PARTY IF OTHER THAN PATIENT OR IF PATIENT IS A MINOR:

NAME: ____

ADDRESS: Street ____

City ____________________ State __________ Zip Code __________

TELEPHONE: Home ____________________ Work ____________________

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

____________________ SIGNED (PATIENT, OR PARENT IF MINOR) __________ DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

____________________ SIGNED (INSURED PERSON) __________ DATE

DENTAL INSURANCE INFORMATION

Our office accepts insurance payments, but we do ask that you pay your co-payment at the time of service. If you have dental insurance, please complete the section below and present your I.D. card to the Business Manager.

NAME OF INSURED: ____________________ INSURED DATE OF BIRTH: ____________________

PATIENT RELATION TO INSURED: ____________________ INSURED SS#: ____________________

INSURED EMPLOYED BY: ____

NAME OF INSURANCE CARRIER: ____

GROUP PLAN I.D. OR POLICY #: ____

I will be paying today with: ___ Cash ___ Check ___ Credit Card

PLEASE NOTE:* *WE DO NOT BILL PATIENTS. PAYMENT IS DUE AT THE END OF THE APPOINTMENT.