Patient Information

Patient Name: _____

Are you?: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Child

Father's Employer (If under the age of 18): _____ Father's Work Phone: _____

Mother's Employer (If under the age of 18): _____Mother's Work Phone: _____

Spouse's Name: _____ Spouse's Employer: _____Spouse's Work Phone: _____

Spouse's Birthdate: _____ Whom may we thank for referring you? _____

Who is financially responsible for this account? _____

Primary Insurance Information

Subscriber Name: _____ Relationship To Patient: _____

Birthdate:_____ SS#_____ Employer: _____

Insurance Company: _____Group #_____ Subscriber #_____

Name of other dependents under this plan: _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name: _____ Relationship To Patient: _____

Birthdate:_____ SS#_____Employer: _____

Insurance Company: _____Group #_____ Subscriber #_____

Name of other dependents under this plan: _____

Release

I authorize the dentist to perform diagnostic procedures and treatment as they may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I, hereby, authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand that my dental care insurance carrier or provider of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full on all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care provider.

Patient or Guardian's Signature _____ **Date:** _____