PATIENT INFORMATION FORM

Today's Date

1 PATIENT INFORMATION

Name _____
First Initial Last Nickname

Address _____
City State Zip

Sex ☐M ☐F Birthdate_____ Marital Status_____

Home Phone _____ Work Phone_____ Patient SS#_____

Occupation _____ Employer _____

Spouse _____ Spouse Birthdate_____ Spouse SS#_____ Employed By_____

If Child-Responsible Party _____ Birthdate _____ SS#_____ Employed By_____

Referred By _____

2 PRIMARY DENTAL INSURANCE

Subscriber Name: _____ Relationship to Patient:_____

Subscriber SS# _____ Employed By _____ Subscriber DOB _____

Ins. Plan Name: _____ Group #_____ BCBS# _____

3 SECONDARY DENTAL INSURANCE

Subscriber Name: _____ Relationship to Patient:_____

Subscriber SS# _____ Employed By _____ Subscriber DOB _____

Ins. Plan Name: _____ Group #_____

4 ACCIDENT CLAIM INFORMATION

Subscriber Name: _____ Relationship to Patient:_____

Subscriber SS# _____ Employed By _____ Subscriber DOB _____

Medical Ins. Plan Name: _____ Group #_____

5 INSURANCE AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance admissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been made.