

welcome

PATIENT NUMBER

Date

Patient's Name Last First Initial Date of Birth Male Female

If Child: Parent's Name

How do you wish to be addressed

Single Married Separated Divorced Widowed Minor

Residence - Street

City State Zip

Business Address

Telephone: Res. Bus.

Fax Cell Phone #

eMail

Patient/Parent Employed By

Present Position

How Long Held

Spouse/Parent Name

Spouse Employed By

Present Position

How Long Held

Who is Responsible for this account

Drivers License No.

Method of Payment: Insurance Cash Credit Card

Purpose of Call

Other Family Members in this Practice

Whom may we thank for this referral

Patient/parent Social Security No.

Spouse/Parent Social Security No.

Someone to notify in case of emergency not living with you

DENTAL INSURANCE 1ST COVERAGE

Employee Name Date of Birth

Employer Name Yrs.

Name of Insurance Co.

Address

Telephone

Program or policy #

Social Security No.

Union Local or Group

DENTAL INSURANCE 2ND COVERAGE

Employee Name Date of Birth

Employer Name Yrs.

Name of Insurance Co.

Address

Telephone

Program or policy #

Social Security No.

Union Local or Group

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of 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, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE