Welcome! How did you hear about us? _____

Patient Information

Name:_____ Birthdate:_____ SSN:_____

Home :_____ Cell :_____ Work:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Drivers License:_____

Marital Status: Minor _____ Single _____ Married _____ Divorced _____ Widowed _____

If Student: Name of School:_____ Full Time _____ Part Time _____

Responsible Party

If patient is a minor: Name of person responsible for the account: _____

Address:_____ City: _____ State:_____ Zip:_____

Home:_____ Cell: _____ Work: _____

Relationship to Patient: _____ Birthdate: _____ SSN:_____

Drivers license:_____ Employer: _____

Dental Insurance Information

Name of Insurance Company: _____ Phone Number:_____

Address:_____ City:_____ State: _____ Zip:_____

Policy Holder:_____ Birthdate: _____ SSN:_____

Member ID Number:_____ Employer:_____

Additional Insurance Company:_____ Phone Number:_____

Address:_____ City: _____ State:_____ Zip:_____

Insured's Name:_____ Birthdate: _____ SSN:_____

Member ID Number:_____ Employer:_____

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 submissions. I authorize the dentist to release information necessary to secure the payments of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance within 60 days.

Patient (Or Guardian's) Signature_____ Date_____