Patient Information

Last Name:__________________First :__________________Middle:_________________

Home address: ____ Apt:________________

City:________________________________ State: _____________ Zip:_______________

Home Phone:___________________________ Cell:______________________________

Sex: **M** or F (Circle one) Marital Status: Married, Single, Divorced, Widowed (Circle One)

Birth Date:______________________ Social Security #:_____________________________

Email Address:____

Referred by:____

Name of Physician:_________________________________Phone:____________________

DO YOU HAVE DENTAL INSURANCE? YES NO (Circle One)

Name of Primary Insurance:________________________Phone:______________________

Group #:______________________________ID#:________________________________

Policy Holder Employer:______________________________Phone:___________________

Primary Insurance Holder Relation to Patient:_______________________________________

Primary Insurance Holder Name:____

Primary Insurance Holder Social Security:______________________DOB:______________

Name of Secondary Insurance (if applicable): _________________Phone: _______________

Group #: ___________________________ID#: ____________________________________

Secondary Insurance Holder Relation to Patient: _____________________________________

Policy Holder Employer: ____

Secondary Insurance Holder Name:____

Secondary Insurance Holder Social Security: _______________________DOB:______________

Person Responsible for Payment:

Name:__________________________SS #:_____________________Phone:______________

Address:______________________ City_______________________State_______Zip______

Drivers License #: ________________________

We hereby jointly and severely agree to pay the dentist and all charges incurred by the above named patients(s) and all cost of collection including reasonable attorney's fees. Insurance claims are filed as a courtesy and amounts are estimated based on available information. Your policy is an agreement between you and your insurance company and does not relieve you of timely payment of this amount. If you have any questions please call your insurance.

Signature:_______________________________________ **Date:**___________________________