PATIENT INFORMATION

NAME _____ **DATE OF BIRTH** _____

ADDRESS _____ **CITY** _____ **STATE** ____ **ZIP**_____

HOME PHONE _____ **CELL PHONE** _____ **SS#** _____

EMAIL _____

CIRCLE APPROPRIATE ONE: MINOR SINGLE MARRIED DIVORCED WIDOWED

IF MINOR PARENT/ GUARDIAN NAME _____

RELATIONSHIP TO PATIENT _____ **DATE OF BIRTH** _____

CONTACT IN CASE OF EMERGENCY_____ **PHONE** _____

PRIMARY INSURANCE

NAME OF INSURED _____ **DATE OF BIRTH** _____

RELATIONSHIP TO PATIENT (CIRCLE ONE) SELF PARENT SPOUSE GUARDIAN

INSURANCE COMPANY_____ **ID#** _____ **GROUP #** _____

ADDRESS OF INSURANCE _____ **PHONE** _____

EMPLOYER _____**WORK #**_____

SECONDARY INSURANCE

NAME OF INSURED _____ **DATE OF BIRTH** _____

RELATIONSHIP TO PATIENT (CIRCLE ONE) SELF PARENT SPOUSE GUARDIAN

INSURANCE COMPANY_____ **ID#** _____ **GROUP #** _____

ADDRESS OF INSURANCE _____ **PHONE** _____

EMPLOYER _____**WORK #**_____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED TO ME, ON BOTH PAGES, TO THE BEST OF MY KNOWLEDGE. THE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH AND OR DELAY BILLING. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION TO THE INSURANCE COMPANY FOR PAYMENT OF CLAIMS. I UNDERSTAND THAT THE OFFICE CHARGES A $25 NO SHOW/CANCELLATION FEE PER ½ HR, $50 FOR SPECIALIST, FOR APPOINTMENTS NOT CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OFFICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

X_____**DATE**_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR