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PATIENT NUMBER

# welcome

Age

Date

Patient's Name

Date of Birth

Male Female

Last, First Initial

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# \_\_\_\_\_

E-Mail

Patient/Parent Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

Time at company \_\_\_\_\_

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. \_\_\_\_\_

Emergency Contact Name, Phone Number

\_\_\_\_\_

## DENTAL INSURANCE 1ST COVERAGE

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

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 \_\_\_\_\_

Relationship to patient \_\_\_\_\_

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 \_\_\_\_\_