PATIENT INFORMATION

RESPONSIBLE PARTY _____ BIRTH DATE _____

ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ CELL PHONE _____ SOCIAL SECURITY # _____

EMPLOYER _____ BUSINESS PHONE _____

SPOUSE'S NAME _____ BIRTH DATE _____

CHILDREN: 1) _____ BIRTH DATE _____

2) _____ BIRTH DATE _____

3) _____ BIRTH DATE _____

REFERRED BY _____

IF YOU HAVE DENTAL INSURANCE PLEASE COMPLETE THE FOLLOWING:

EMPLOYEE/SUBSCRIBER NAME _____ BIRTH DATE _____

SOCIAL SECURITY # _____ / OR EMPLOYEE ID # _____

EMPLOYER NAME _____

DENTAL INSURANCE COMPANY _____

ADDRESS _____ CITY, STATE, ZIP _____

GROUP/POLICY # _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY DENTAL TREATMENT.	I HEREBY ASSIGN ANY INSURANCE BENEFITS PAYABLE TO ME TO BE PAID DIRECTLY TO MY DENTIST.
▶ _____ _____	▶ _____ _____
SIGNED (PATIENT, OR PARENT IN MINOR) DATE	SIGNED (INSURED PERSON) DATE

DOES YOUR SPOUSE ALSO HAVE DENTAL INSURANCE? YES NO (CIRCLE ONE)

IF YES, COMPLETE THE FOLLOWING:

EMPLOYEE/SUBSCRIBER NAME _____ BIRTH DATE _____

SOCIAL SECURITY # _____ / OR EMPLOYEE ID # _____

EMPLOYER NAME _____

DENTAL INSURANCE COMPANY _____

ADDRESS _____ CITY, STATE, ZIP _____

GROUP/POLICY # _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY DENTAL TREATMENT.	I HEREBY ASSIGN ANY INSURANCE BENEFITS PAYABLE TO ME TO BE PAID DIRECTLY TO MY DENTIST.
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