Welcome

PATIENT INFORMATION

Name:_____ I prefer to be called:_____

Address:_____ City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Date of Birth:_____ SS#:_____ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Who May We Thank for Referring You Here?_____

Please Circle: (**H**ome / **W**ork/ **C**ell / **E**mail / **T**ext) Recare Postcard: ___ Mail Statements: ___ Mail
Confirm Appointments: **H W C E T** ___ Email ___ Email

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Homemaker ❑ Retired ❑ Self Employed ❑ Student ❑ Unemployed

Employer: _____ Job Title / Position: _____

Employer Address:_____ City, State, Zip:_____

Employer Phone:_____Ext. _____ May we call you at work? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE INFORMATION

Employer Name:_____

Subscriber Name:_____ Relationship to Patient:_____

Date of Birth:_____ Social Security Number:_____

Subscriber Address:_____ City, State, Zip:_____

Home Phone:_____ Cell Phone:_____

Primary Insurance Company:_____ Phone #:_____

Address:_____ City, State, Zip:_____

Subscriber #:_____ Group #:_____ Effective Date:_____

SECONDARY DENTAL INSURANCE INFORMATION

Employer Name:_____

Subscriber Name:_____ Relationship to Patient:_____

Date of Birth:_____ Social Security Number:_____

Subscriber Address:_____ City, State, Zip:_____

Home Phone:_____ Other Phone:_____

Secondary Insurance Company:_____ Phone #:_____

Address:_____ City, State, Zip:_____

Subscriber #:_____ Group #:_____ Effective Date:_____

SEE REVERSE SIDE

IF THE PATIENT IS UNDER AGE 18, PARENTAL / GUARDIAN INFORMATION

Name:_____ Relationship to Patient:_____

Address:_____ City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Date of Birth:_____ SS#:_____ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Homemaker ❑ Retired ❑ Self Employed ❑ Student ❑ Unemployed

Employer: _____ Job Title / Position: _____

Employer Address:_____ City, State, Zip:_____

Employer Phone:_____Ext.: _____ May we call you at work? ❑ Yes ❑ No

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Name:_____ Relationship to Patient:_____

Address:_____ City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Date of Birth:_____ SS#:_____ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Homemaker ❑ Retired ❑ Self Employed ❑ Student ❑ Unemployed

Employer: _____ Job Title / Position: _____

Employer Address:_____ City, State, Zip:_____

Employer Phone:_____Ext. :_____ May we call you at work? ❑ Yes ❑ No

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PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

I understand that payment is due on the day service is rendered unless other arrangements have been made in advance. I agree to accept full responsibility for the payment of services rendered and all costs incurred in the collection of those fees.

If my insurance carrier is billed for services rendered, I hereby authorize payment be made directly to the physician. I also authorize the release of any information acquired in the course of my examination or treatment to my medical insurance carrier(s).

I hereby authorize photocopies of this form to be valid as the original.

DATE:_____ PATIENT'S SIGNATURE:_____

(IF MINOR, PARENT / GUARDIAN SIGNATURE)