PATIENT INFORMATION

Patient Name:_____ Date: _____

Address: _____Apt #:_____

City: _____State: _____Zip: _____

Phone (home): (_____)_____ -_____ Phone (cell): (_____)_____ -_____

Birthdate: _____SS#:____-____-_____ Gender: _____

Occupation: _____ Single / Married / Partner / Widowed / Divorced
(parent / guardian if minor)

Employer: _____ Phone (work): (___)_____ -_____

Employer Address: _____

City: _____State: _____ Zip: _____

Person Responsible for payment: _____

Name of Spouse / Partner:_____

Spouse's / Partner's Employer: _____Phone (work): (___)_____ -_____

Employer Address: _____

Referring Dentist: _____

If you have Dental Insurance:

Primary Insurance Carrier: _____

Insurance Carrier address: _____

Name of Policyholder: _____

Social Security #: _____-_____-_____ Group #:_____

Employer: _____

Secondary Insurance Carrier: _____

Insurance Carrier address: _____

Name of policyholder: _____

Social Security #: _____-_____-_____ Group #:_____

Employer: _____

Payment for services is the responsibility of the patient and is payable by the time treatment is completed. In the event you have dental insurance, we will accept direct assignment of benefits (if such benefit coverage can be pre-determined.) We will be happy to assist in the preparation of insurance forms.

Patient Signature: _____Date: _____