W E L C O M E

Patient Information

Date_____ID#/SS#_____

Patient_____

Birthday_____Age_____

Address_____

_____
City State Zip

Occupation_____

Employer_____

Employers Address_____

Employers Phone_____

Spouse's name_____

Birthday_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you? _____

_____
Internet ____ Insurance Co.____ Phone book___

E-mail address to confirm appointments:

_____

Dental Insurance

Who is responsible for account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

I.D. #_____
Is patient covered by additional insurance?___Y___N

Subscriber's Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to DR._____ all insurance benefits. If any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

PHONE NUMBERS

Home (___) _____Work (___) _____Cell (___) _____Spouse's Work (___) _____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your house hold.)

Name_____Relationship_____Home_____Work_____