CONFIDENTIAL PATIENT INFORMATION

NAME _____ DATE _____

DATE OF BIRTH _____ How did you hear about us? _____

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:

_____

RELATIONSHIP TO PATIENT: _____
ADDRESS: _____
HOME PHONE: _____ CELL PHONE:_____
EMPLOYER: _____ WORK PHONE: _____
IS THIS PERSON CURRENTLY A PATIENT IN OUT OFFICE? _____YES _____ NO

INSURANCE INFORMATION:

NAME OF INSURED: _____
RELATIONSHIP TO PATIENT: _____
BIRTHDATE: _____ SOCIAL SECURITY #: _____
EMPLOYER:_____ WORK PHONE: _____
ADDRESS OF EMPLOYER: _____

DENTAL INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____
_____
GROUP #: _____ INSURANCE IDENTIFICATION# _____

DO YOU HAVE ADDITIONAL INSURANCE? _____ IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED: _____
RELATIONSHIP TO PATIENT: _____
BIRTHDATE: _____ SOCIAL SECURITY #: _____
EMPLOYER:_____ WORK PHONE: _____
ADDRESS OF EMPLOYER: _____

DENTAL INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____
_____
GROUP #: _____ INSURANCE IDENTIFICATION# _____

PLEASE NOTE: It is your responsibility to give our office your dental insurance information. Should we not have the correct information from you to bill your insurance, you will be responsible for any amount due on your account.

_____
SIGNATURE OF PATIENT (OR PARENT IF MINOR)