PATIENT INFORMATION

CHART # ____________________

PATIENT

Name______________________________
Last First
Address ___________________________
City _______________ Zip ___________
Home ( ) __________________________
Cell # ( ) _________________________
Soc. Sec # _________________________
DL # _____________________________
Birthday ___________________________
Email _____________________________

RESPONSIBLE PARTY

Name _____________________________
Last First
Address ___________________________
City ______________ Zip_____________
Home # ( ) _________________________
Cell #_____________________________
Soc. Sec # _________________________
DL # _____________________________
Birthday __________________________

EMPLOYMENT

Employer __________________________
Occupation ________________________
Address ___________________________
City ________________ Zip ___________
Business # ( ) ______________________

EMERGENCY CONTACTS

(1) Spouse _________________________
Last First
Cell/Work # ( )_____________________

(2) Name __________________________
Last First
Cell/Work # ( ) _____________________

GETTING TO KNOW YOU

How did you hear about us? ____________
Please list family who are patients at our facility:
1. __________________________________
2. __________________________________
3. __________________________________

INSURANCE

Insurance Name:

____
Please circle: HMO - PPO
Insured's Name _____________________
Insured's Soc. Sec # _________________
Insured's Birthday ___________________

1. I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.
2. I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.

X __________________________________
Signature of Patient or Responsible Party if Child