

TODAYS DATE: _____

How did you hear about our practice? _____ Social Security # _____

Patient's Name _____ Marital Status S M D Sep W Birthdate _____

Address _____ City _____ ST _____ ZIP _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager _____ E-Mail _____

Employer _____ City _____ Occupation _____

Name of Spouse / Parent / Guardian _____ Birthdate _____
(circle one) Social Security # _____

Address if different _____ City _____ ST _____ ZIP _____

Home Phone _____ Work Phone _____ Ext _____

Employer _____ City _____ Occupation _____

In case of emergency, whom shall we notify other than spouse?

Name _____ Relationship _____ Phone _____

DENTAL INSURANCE INFORMATION

SECONDARY DENTAL INSURANCE INFO

EMPLOYEE NAME _____

EMPLOYEE NAME _____

INS CO NAME _____

INS CO NAME _____

INS CO ADDRESS _____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP _____

INS CO CITY, ST ZIP _____

INSURANCE PHONE _____

INSURANCE PHONE _____

GROUP / POLICY # _____

GROUP / POLICY # _____

EMPLOYEE SS # _____

EMPLOYEE SS # _____

BIRTHDATE _____

BIRTHDATE _____

ASSIGNMENT and RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records may be used by the dentist if he so determines. If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical expert for any needed evaluation.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I certify that I have read or had read to me, the contents of this form.

: Signature _____ Date _____

Parent or Guardian if a minor

PATIENT INFORMATION QUESTIONNAIRE