PATIENT INFORMATION FORM

Date: ___-___-____

First Name: _____ M.I. ____ Last Name: _____
Date of Birth: ____-____-_____ Age: _____ Sex: M F S.S # _____ - _____ - _____
Single Married Divorced Widowed Minor
Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____
Home Phone: _____-_____-_____ Business: _____-_____-_____ Cell: _____-_____-_____
Employer Name & Address: _____
_____

Student: Full-Time ☐ Part-Time ☐ Name of School: _____

Who Referred you? _____
Name of your Dentist: _____ Address: _____
Have you or anyone in your family been treated in this office in the past? Y ☐ N ☐
If Yes, list the person(s): _____

Person responsible for this account: _____ DOB: _____
Relationship to patient: _____ S.S # _____ - _____ - _____
Email Address: _____
Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____
Home Phone: _____-_____-_____ Business: _____-_____-_____ Cell: _____-_____-_____
Employer Name & Address: _____

PRIMARY INSURANCE CO.	SECONDARY INSURANCE CO.
Insurance Name:	Insurance Name:
Address:	Address:
Phone: ( ) -	Phone: ( ) -
Insured Name:	Insured Name:
S.S. #	S.S. #
Group #: Pt. ID#:	Group #: Pt. ID#:
Dental ☐ Medical ☐	Dental ☐ Medical ☐

FEES and PAYMENTS

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the doctor named of the insurance benefits otherwise payable to me. If the account is turned over to collections, the responsible party(s) agrees to pay all collection and attorney fees.

SIGNATURE: _____ Date: ___-___-____

(Rev3/18)