Today's Date_____

PATIENT INFORMATION:

Last Name_____ First Name_____ Mid_____

Address_____ City/State_____ Zip_____

Home Phone#_____ Business Phone#_____ Cell Phone#_____

Patient Employer_____ Preferred Pharmacy_____

Patient Social Security#_____ Date of Birth_____ Email_____

SPOUSE/PARENT/GUARDIAN INFORMATION (Circle one)

Name_____ Phone number_____

Address (if different)_____ City/State_____Zip_____

PRIMARY DENTAL INSURANCE INFORMATION:

Subscriber Name_____

Ins Co Name_____

Ins Co Address_____

City/State/Zip_____

Member/Subscriber ID#_____

Group Policy #_____

Subscriber Date of Birth_____

SECONDARY DENTAL INSRUANCE INFORMATION:

Subscriber Name_____

Ins Co Name_____

Ins Co Address_____

City/State/Zip_____

Member/Subscriber ID#_____

Group Policy #_____

Subscriber Date of Birth_____

Assignment & Release: I hereby authorize my insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required for this claim. I authorize that my records can be used by the dentist if he so determines. I understand that my insurance plan is a contract between myself, and the insurance company and that the dentist files a claim with my insurance company as a courtesy to me. I understand that I am financially responsible for any unpaid balance

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the dentist in scientific papers or demonstrations. I certify that I have read or had read to me the complete contents of this form.

I agree to the above**: Signature**_____**Date**_____

(Parent or guardian IF patient is a minor)

What method of payment will you be using today? Cash___Check____Visa/MC____AMEX____DISC____CareCredit____

REFERRING DENTIST_____ How did you hear about us?_____