Patient Information

Personal Information

Name: _____ Social Security No. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Birth Date: _____ Sex: _____ Marital Status: _____ Spouse: _____

Occupation: _____ Referred By: _____

Person to Be Contacted In Case Of Emergency (Other Than Relative)

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Person Responsible For Account

Name: _____ Relationship: _____ SS No. _____

Birth Date: _____ Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance Information

Primary Insurance Co: _____

Address: _____

Primary Acc. Holder: _____ Relationship: _____

SS No. _____ Birth Date: _____ Policy/Group #: _____

Employer: _____

Secondary Insurance Co: _____

Address: _____

Secondary Acc. Holder: _____ Relationship: _____

SS No. _____ Birth Date: _____ Policy/Group #: _____

Employer: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my personal or medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand that a 1 ½% finance charge will be added to any balance over 60 days. In the event of default I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of the note.

Signature _____ Date _____