

**PATIENT INFORMATION**

Patient's First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Sex: M F

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

Dentist \_\_\_\_\_ Orthodontist \_\_\_\_\_ Referred By: \_\_\_\_\_

Are you a student? No Yes If yes, Full-time Part-time School \_\_\_\_\_

Are you employed? No Yes If yes, Full-time Part-time Employer \_\_\_\_\_

Marital Status Single Married Widowed

**RESPONSIBLE PARTY INFORMATION**

Who will be responsible for paying any amount not paid by insurance? Self Spouse Mother Father Other

Name \_\_\_\_\_ HomePhone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security Number \_\_\_\_\_ Employer \_\_\_\_\_

**DENTAL INSURANCE INFORMATION (PRIMARY)**

**SECONDARY DENTAL INSURANCE INFORMATION**

Insurance Co. \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone \_\_\_\_\_

Insurance Co. Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's ID or SSN \_\_\_\_\_

Insured's ID or SSN \_\_\_\_\_

DOB \_\_\_\_\_ Employer \_\_\_\_\_

DOB \_\_\_\_\_ Employer \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Group # \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Group # \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

**EMERGENCY CONTACT**

Insurance Co. \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Relation \_\_\_\_\_

Phone \_\_\_\_\_

Phone Number \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's ID or SSN \_\_\_\_\_

DOB \_\_\_\_\_ Employer \_\_\_\_\_

Please remember that 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, co-insurance, or any other balance not paid for by your insurance company.

My signature below is authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist of insurance benefits otherwise payable to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_ (Parent / guardian must sign if patient is under 18 years of age)