

# Welcome

Thank you for selecting our dental health team. We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely. If you have any questions we will be happy to help.

## **Patient Information**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc.Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone\_(\_\_\_\_\_) \_\_\_\_\_ Work Phone\_(\_\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_  
Check appropriate box    Minor    Single    Married    Divorced    Widowed  
Patient's or Parent's Employer \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_

## **Responsible Party**

Name of Person Responsible for account \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN# \_\_\_\_\_

## **Insurance Information**

Name of Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SSN# \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_  
Address of Insurance Company \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_ Envoy # \_\_\_\_\_

## **Secondary Insurance Information**

Name of Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SSN# \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_  
Address of Insurance Company \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_ Envoy # \_\_\_\_\_

## **Release**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full on all accounts. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part by my dental care payor. I understand that payment is due at time of service unless other arrangements have been made.

**Patient's or Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_