# *WELCOME!*

Thank you for choosing our office. \Ve strive to provide you with the most gentle, quality care possible. If you have any questions, or we can help you in any way, please feel free to ask.

## *Patient Information (Confidential):*

Name_____ (If child, parent/guardian name)_____

*Last Name First Name Middle Initial*

Birthdate_____ Sex _____ Age_____

Soc. Sec. #_____ Home Address

_____

City_____ State_____ Zip _____

Home Phone_____ Work Phone_____ Cell phone _____

E-Mail_____ Drivers License #_____

How did you hear about our practice?_____

Employer_____ Occupation_____

How long there?_____ May we call?_____

Employer Address_____City_____ State_____ Zip_____

Spouse's Name (Or other parent/guardian)_____

Soc. Sec. #_____

Spouse's Employer_____ Occupation _____

How long there?_____ May we call?_____

Spouse's Employer_____ Address_____

City_____ State_____Zip_____

If patient is a student: Name of school/college: _____

### *Primary Insurance:*

Name of Insured: _____ Birthday _____

Relationship to patient: _____ Address (if different from patient)_____
Dental Insurance Co. _____ Phone: _____

Social Security # _____Subscriber ID # _____

Group, Contract or Local or Union #_____

### *Additional Insurance:*

Name of Insured: _____ Birthday _____

Relationship to patient: _____ Address (if different from patient)_____
Dental Insurance Co. _____ Phone: _____

Social Security # _____Subscriber ID # _____

Group, Contract or Local or Union #_____

## *Copayments:*

To accept insurance, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check:

CIRCLE ONE: Visa | MasterCard | Discover | Amex |

Account #: _____ Expiration date: _____

Name on card_____ CVW#_____

❑ Credit Card ❑ Debit Card ❑ ATM ❑ Voided check attached.

### *In Case of Emergency:*

Name and City of primary care physician: _____

Someone we may contact, not living with you: _____

Phone #'s (home, work cell): _____

## *Authorization:*

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. 1 authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I further authorize this office to charge my credit card to cover any unpaid fees not paid by insurance within 60 days. 1 understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts. I have received a copy of this office's Notice of Privacy Practices.

Signature_____Date_____