WELCOME!

Date: _____

Patient's/Child's Name _____ Date of Birth: _____ ☐ M ☐ F
Last First MI

GUARANTOR INFORMATION:

Mother's Name: _____

DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Single Married Separated Divorced Widowed

Home Phone: _____

Work Phone: _____

Cell Phone: _____

SSN: _____

Employer: _____

****

Father's Name: _____

DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Single Married Separated Divorced Widowed

Home Phone: _____

Work Phone: _____

Cell Phone: _____

SSN: _____

Employer: _____

Who is responsible for this account? _____

Referral Source: _____

****

EMERGENCY CONTACT:

Name and phone number of person to be reached in case of emergency.

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

PRIMARY DENTAL INSURANCE:

Policy Holder: _____ DOB: _____

Employer Name: _____

Insurance Company: _____

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Policy #: _____ Group #: _____

SSN: _____

****

SECONDARY DENTAL INSURANCE:

Policy Holder: _____ DOB: _____

Employer Name: _____

Insurance Company: _____

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Policy #: _____ Group #: _____

SSN: _____

****

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than that of the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest to the accuracy of the information on this page.

_____

PATIENT'S OR GUARDIAN'S SIGNATURE DATE