_______/_______/_______ SSN: ________-________-_________

Date of Birth

Patient's Name: ____

If Child: Parent's Name: ____

Last First Initial

Purpose of this visit: ____

Our office uses texts, e-mails and voicemail to remind patients of their appointments. What is the best contact information for the following?

Text:_________________________Phone:_________________________E-mail:___________________________

Patient/Parent Employed By:_____________________________________Work #:_________________________

Drivers License #:____

Spouse/Parent Name:____Work #:_________________________

Spouse Employed By:____

Who is responsible for this account?:____

How did you hear about us?:____

Whom may we thank for the referral? (we would like to send them a gift card)__________________________________

Primary Dental Insurance

Employee Name:_______________________________________ SSN:___________________________________

Employer Name:_______________________________________ # of Yrs:________________________________

Name of Insurance Co:_________________________________ Phone:_________________________________

Address:____Policy #:________________________________

Union Local or Group:__________________________________Employee DOB:_________________________

Secondary Dental Insurance

☐ Yes ☐ No If yes, please write the necessary information on the back of the form

I CONSENT TO:

- The diagnostic procedures and treatment by the dentist necessary for proper dental care.
- 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.
- Please list the names of those that we can discuss your patient and financial information with.
  Example: Spouse/Parent:____

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than 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 payor.

I agree that this practice may e-mail / text me about my patient information and finances at the following:
Email:____Text:_________________________

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

Patient/Guardian Signature:____

Date: ______/______/______