

DENTAL ASSOCIATES

Thank you for choosing Dental Associates. In order to serve you properly, we will need the following information. All information will be strictly confidential.

➤Please Print Clearly<

Patient Name: _____ Date of Birth: ___/___/___
Last Name First Name Male / Female

Address: _____ City: _____ ST: _____ Zip Code _____

Home Phone:() _____ Work Phone:() _____ Ext. or VM#: _____

☒ E-Mail Address: _____ Cell Phone #: () _____

Best Number to be reached during the day: _____

Patient's Social Security # : ___/___/___ Marital Status: _____

If patient is full time college student, state college name & location: _____

Person responsible for billing: Name: _____ Self / Parent / Guardian / Spouse

Address & Phone # _____ Social Security # ___/___/___

Doctor you will see today: _____ Referred by: _____

At any time, was any member of your family treated as a patient in our office? Yes / No

If yes, please list all name(s): _____

☎ In case of emergency: Whom may we contact? Name: _____
Relationship : _____ Phone Number: H# _____ W# _____

✓ Is patient covered by dental insurance: Yes / No If Yes, please provide:

Insured's Name: _____ Relationship to patient: _____

Insured's Employer: _____ Insured's Social Security# ___/___/___

Name, Address & Phone # of Insurance Co.: _____

Group #: _____ Subscriber ID#: _____ Insured's DOB: _____

✓ Is patient covered under a **secondary** dental insurance? Yes / No If yes, please provide:

Insured's Name: _____ Relationship to patient: _____

Insured's Employer: _____ Insured's Social Security # ___/___/___

Name, Address & Phone # of Insurance Co: _____

Group #: _____ Subscriber ID#: _____ Insured's DOB: _____

☞ I authorize this office to release any information necessary to expedite my insurance claims. I understand that I am responsible for all charges and finance charges of 1.5 % per month (18% APR), regardless of insurance coverage and any collection fees, court costs, and a reasonable attorney's fee, if incurred, on any unpaid balance after 90 days. All information provided is correct & I have read & understand my responsibilities. ☞

✍ Print name: _____ Self/ Patient / Parent / Guardian

Signature: _____ Date: _____
