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 collection fees of 15%, 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:_____
