



Patient Information

Name	Birth date	SS #	
Address	City	State	Zip
Phone # (Home)	(Cell)	(Work)	
Sex M / F	Marital Status	Email	
Employer/School	Employer/School Phone #		
Address	City	State	Zip
Spouse or Parents Name	Employer	Phone #	
Person to contact in case of Emergency	Phone #		
Whom may we thank for Referring you?			

Insurance Information

Name of Insured	Relationship to Patient		
Birthdate	SS #	Date Employed	
Employer	Work Phone #		
Employer Address	City	State	Zip
Insurance Company	Group #		
Address	City	State	Zip

Secondary Insurance Information

Name of Insured	Relationship to Patient		
Birth date	SS #	Date Employed	
Employer	Work Phone #		
Employer Address	City	State	Zip
Insurance Company	Group #		
Address	City	State	Zip

I authorize the Insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

Signature

Date