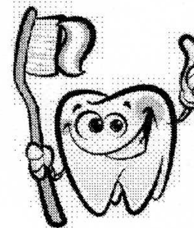
# WELCOME!



Please take a few minutes to fill out the following forms as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you on your journey to a healthy smile!

## Patient Information

Name ________________________________________ Birthdate ___/___/_____ Age ____
*Last Name* *First Name* *Initial*

Address ________________________________________

City ____________________ State______ Zip __________ Home Phone ____________________

Cell Phone ____________________ Email ____________________

Sex: ☐ M ☐ F Social Security # ____________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer ____________________ Occupation ____________________ Business Phone ____________________

Whom may we thank for referring you? ____________________

☐Website ☐Radio ☐Vivo/Valpak ☐Insurance Co. ☐Family/Friend ☐Other ____________________

Emergency contact ____________________ Relationship ____________________

Contact Phone ____________________

## Primary Dental Insurance

☐ Same as above Subscriber Name ________________________________________
*Last Name* *First Name* *Initial*

Relation to Patient ____________________ Birthdate ___/___/_____ Soc. Sec. # ____________________

Address (if different from patient) ____________________ Home Phone ____________________

City ____________________ State __________ Zip ____________________

Cell Phone ____________________ Email ____________________

Employer ____________________ Occupation ____________________

Insurance Company ____________________ Phone ____________________

Subscriber ID # ____________________ Group # ____________________

## Additional Dental Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ____________________ Relation to patient ____________________ Birthday ___/___/_____

Home Phone ____________________ Cell Phone ____________________ Soc. Sec. # ____________________

Insurance Company ____________________ Phone ____________________

Subscriber ID # ____________________ Group # ____________________

## Authorization

♦ I have reviewed the information, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

♦ I authorize the insurance company indicated on this form to pay to 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 that I am financially responsible for all charges whether or not paid by insurance.

Signature ________________________________________ Date ____________________