Patient Information Form

Last Name _____ First Name _____ M.I. _____

Social Security Number _____ Date of Birth_____ Sex: □ M □ F

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail_____

Please select all the methods you would like to confirm your appointments: □ Text □ Phone Call □ E-mail

Can we discuss privileged information or send you documents via e-mail? □ Yes □ No

Patient Employed by: _____ Occupation_____

Work Phone_____ Ext._____ Can we contact you at your work phone? □ Yes □ No

Emergency Contact: _____ Relationship: _____Phone _____

Whom may we thank for referring you? _____

Name of Preferred Pharmacy: _____ Phone_____

Primary Insurance

Policyholder Name: _____ Policyholder Birthdate: _____

Policyholder Soc. Sec. Number_____ Employed by _____

Address (if different from patient's) _____ City_____ State/Zip _____

Insurance Company _____ Subscriber Number_____

Authorization

- I hereby authorize my insurance company to pay the dentist or dental group 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 my insurance.**
- I understand that any credit granted will be paid in accordance with agreement, and that this office may charge a finance charge of 1 ½ % per month to any balance. In the event of default, collection/attorney fees may apply.
- **I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.**

Signature of Patient or Legal Guardian _____ Date _____