Patient Information

Full Name_____ Date of Birth _____

Address_____ City_____ State_____ Zip code_____

Telephone: Home_____ Work_____ Mobile_____

Email Address_____ Gender_____ Employer_____

Emergency Contact Name_____ Phone _____ Relationship_____

Guardian or Responsible Party (if different than above):

Full Name_____ Relationship_____

Address_____ City_____ State_____ Zip code_____

Telephone: Home_____ Work_____ Mobile_____

Insurance Policy (if applicable):

Name of Policy Holder_____ Date of Birth_____

SSN#_____ Employer_____ Insurance Company_____

Address_____ City_____ State_____ Zip code_____

Policy #(member ID)_____ Group #_____ Phone_____

Secondary Policy (if applicable):

Name of Policy Holder_____ Date of Birth_____

SSN#_____ Employer_____ Insurance Company_____

Address_____ City_____ State_____ Zip code_____

Policy #(member ID)_____ Group #_____ Phone_____

If you have more than 2 dental insurance policies, please notify our staff.

We are happy to assist you in understanding and filing your insurance for most dental procedures. Please remember your insurance is a contract between you, your employer, and your insurance company. Please understand that we can't speak on their behalf. We will gladly act as an advocate but can't be responsible for settling any disputed claims or coverage. We require payment of patient's estimated portion at the time of treatment. Our office policy states that you are solely responsible for your bill. If we don't receive payment from your insurance carrier within 60 days, we will notify you. Failure of your insurance carrier to reimburse our office within 60 days will result in our billing you directly for the remaining balance.

_____ _____ _____

Patient Name (Print) **Patient/Guardian Signature** **Date**