PATIENT INFORMATION

Patient's Name	Patient's Spouse / Parent/Guardian
Address	Address
City, Zip	City, Zip
Phone # Home Work Cell	Phone # Home Work Cell
E-Mail Address	E-Mail Address
Date of Birth Social Security No.	Date of Birth Social Security No.
Sex Male Female Marital Status	Sex Male Female Marital Status
Employer Phone #	Employer Phone #
Whom may we thank for referring you?	
EMERGENCY CONTACT PHONE #	

INSURANCE INFORMATION

Patients with insurance are responsible for payment of their bills. We do not have contracts with insurance carriers. It is not always possible to predict which services the carrier covers or how much they will pay for a particular service. We will assist you in every way possible with your insurance carrier.

	PRIMARY INSURANCE	SECONDARY INSURANCE
Employee's Name		
Social Security No.		
Employee's Date of Birth		
Insurance Company Name		
Insurance Company Address		
Insurance Company Phone #		
Group #		
Subscriber #		
Family Members Covered		

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information required for this claim I authorize that the doctor can use my records if he so determines. In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy. If this account is assigned to an outside agency for collection, I/we agree to pay all attorney fees, court costs and any collection charges which will be added to the outstanding balance of my account.

I consent to the taking of photographs and x-rays before, during and after treatment and to the use of it by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE____**DATE**__________________________________