Patient Information Form

YOUR PRACTICE NAME (on practice letterhead)

PATIENT INFORMATION

Name: _____ _____ _____ ☐ Male ☐ Female
Last First MI

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. How do you wish to be addressed: _____

Address: _____
Mailing address City State ZIP

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Date of Birth: _____ Social Security Number: _____ Employer: _____

Who may we thank for referring you to our practice? _____

DENTAL INSURANCE INFORMATION

Employee/Subscriber Name: _____
Last First MI

Date of Birth: _____ Subscriber ID#: _____

Group/Employer Name: _____ Group Number: _____

Insurance Company Name: _____

Claims Mailing Address: _____

_____

Telephone Number: _____

☐ I authorize release of any information concerning my/my child's healthcare recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.

☐ I authorize payment of insurance benefits directly to (name of practice).

☐ I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.

☐ I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment.

☐ I agree to pay any applicable deductibles and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.

☐ I agree to pay the total cost of dental services rendered on the date of service if I/my child does not have dental insurance benefits.

Patient/Guardian Signature: _____ Date: _____