Adult Patient Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City/State: _____

Zip Code: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Soc. Sec. #: _____- _____-_____

O Male O Female Email Address: _____

O Single O Married

Your Employer:_____ Occupation:_____

Do you have dental insurance through ***your*** employer? O Yes O No

Name of insurance company: _____ Your Ins. ID #: _____
(May not be same as SS#)

Spouse Information

Spouse's name:_____ Date of Birth: _____/_____/_____

Soc. Sec #: _____-_____-_____

Employer: _____ Occupation:_____

Does your spouse have dental insurance through ***his/her*** employer? O Yes O No Group #: _____

If yes, are you covered under your spouse's insurance? O Yes O No

Name of insurance company:_____ Spouse's Ins. ID#: _____
(May not be same as SS#)

Additional Information

Who referred you to our office?_____

In case of emergency, contact:_____ (_____)_____-_____
Name Phone Number

Your signature authorizes the release of information to your insurance company and it authorizes the assignment of benefits. **Patients are responsible for all costs not covered by their insurance company.** There is a 2% monthly finance charge on overdue accounts. Fees for collection agency will be added to your account. Your signature also authorizes the use of your records and clinical photographs for scientific publication or teaching provided your name remains anonymous.

X_____ _____/_____/_____
Signature Date

Updated: _____ _____ _____ _____ _____
Date and Initials