***PATIENT INFORMATION*** Date:_____

First Name: _____MI:_____Last Name:_____

Birth Date:_____ Soc Sec:_____ Drivers Lic:_____

Street Address: _____City, State, Zip:_____

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Cell: _____

Employer:_____ Work Phone: _____ Ext: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

If married name of Spouse: _____ Work phone#: _____

Emergency Contact: _____ Phone#: _____

Whom may we thank for referring you: _____

***PRIMARY INSURANCE INFORMATION***

Name of Insured:_____ Relationship to Insured: Self Spouse Child Other

Insured Birth Date:_____ Insurance ID#: _____ Group Number: _____

Insurance Company: _____ Employer _____

Address: _____ City, State, Zip: _____

***SECONDARY INSURANCE INFORMATION***

Name of Insured:_____ Relationship to Insured: Self Spouse Child Other

Insured Birth Date:_____ Insurance ID#: _____ Group Number: _____

Insurance Company: _____ Employer _____

Address: _____ City, State, Zip: _____

***AUTHORIZATION AND AGREEMENT WITH DENTISTS, INC.***

I authorize my insurance company to pay to 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 release of information to all my insurance companies. I understand that I am financially responsible to Dentists, Inc. for payment of all services rendered on my behalf, or on behalf of my child, children, or dependents whether or not paid by insurance.

I understand that payment is due in full at the time of treatment unless prior arrangements have been approved.

Signature_____ Date _____