WELCOME

Patient Information

Today's Date_____

Patient Name _____

Date of Birth _____

Social Security Number_____

Mailing Address_____

City_____

State_____ Zip _____

E-mail_____

Sex □ Male □ Female Age_____

□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Other

Occupation_____

Patient Employer_____

Employer Address_____

Work Phone Number_____

Who may we thank for referring you?

_____

Patient Contact Numbers

Home: ( )_____
Cell Phone: ( )_____

_____

Emergency Contact(s) (Specify someone who does not live in your household).

Name_____ Relationship_____
Home Phone ( )_____Work Phone ( )_____

For Self Paying Patients:

Who is responsible for account? _____
Relationship to Patient? _____

Dental Insurance Information

Who is responsible for this account? _____
Relationship to Patient_____

Subscriber Name _____
Relationship_____
Employer_____
Primary Insurance_____
Member ID Number _____
Social Security Number_____
Date of Birth _____
Is patient covered by additional insurance?
□ Yes □ No

Subscriber Name _____
Relationship_____
Employer_____
Secondary Insurance_____
Member ID Number _____
Social Security Number_____
Date of Birth _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with

_____
Name of Insurance Co.

and assign directly to Premier Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Premier Dentistry may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, or Guardian or Personal Representative Date

_____
Print Name of Patient, Parent, Guardian, or Personal Representative Date

_____
Relationship to Patient