

## Patient Information

Mr.     Ms.  
 Mrs.    Miss  
 Dr.

Single     Married  
 Divorced    Separated  
 Widow/Widower

### Patient's Legal Name

Last Name:		First Name:		M.I.:	Nickname:	
Patient's Birth date:		if Minor: Parent's Last Name:		Parent's First Name:		
Patient's Social Security No.:		If Minor: Parent's Social Security No.:		Home/Cell Phone No.:		
Street Address:			City:		State:	Zip:
Employed By:			City:		State:	Zip:
Present Position:			Employed for: _____ years		Business Phone:	
Spouse Name:		Social Security No:		Number of Members in Household:		
Employed By:			City:		State:	Zip:
Present Position:			Employed for: _____ years		Business Phone:	

### Person to Contact for Emergency

Name:	Relationship:	Phone Number:
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### Insurance Coverage Information

Insurance Company:	Subscriber:	DOB:
Telephone No.:	Subscriber SS No.:	

Person Responsible for Payment:			
Address if different from above:	City:	State:	Zip:

Is another member of your family a patient in our practice?	How did you hear about our practice?
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**Regarding your insurance:**

We will be happy to assist you in submitting your insurance claims and will be glad to discuss "Assignment of Benefits" with you. We urge you to be fully informed concerning your dental insurance.

**Our Company Policy is:**

1. The patient (or responsible party) is fully responsible for payment of any unpaid balance for all incurred expenses for dental treatment.
2. We will process your insurance form for you after you assign payment of benefits to the office.
3. Patient (or responsible party) must pay the yearly deductible and any amount (or percentage) not covered by insurance, at the time of service.
4. Insurance will only give us an estimate of what benefit will be paid, any difference between our estimate and the actual insurance payment is the responsibility of the patient.

I have read the policy above, and by my signature below, I understand and agree with the terms of the company policy.

\_\_\_\_\_  
Signature of Person Responsible for Payment

\_\_\_\_\_  
Date