PRIMARY INSURANCE or RESPONSIBILITY

Person responsible ☐Male ☐Female
for account | Last | First | Date of Birth | Relationship to Patient | Sex

Social Security # _____ ☐Single ☐Married ☐ Divorced ☐Separated ☐ Widowed

Address (if different from patient) | City | State | Zip | Home Phone | Cell Phone

Employer
Address | City | State | Zip | Business Phone

Insurance
Company | Group number | Policy/subscriber number | Phone number | Contact person

Spouse ⊥
Names of other dependents covered under this policy

ADDITIONAL INSURANCE or RESPONSIBILITY

Person responsible ☐Male ☐Female
for account | Last | First | Date of Birth | Relationship to Patient | Sex

Social Security # _____ ☐Single ☐Married ☐ Divorced ☐Separated ☐ Widowed

Address (if different from patient) | City | State | Zip | Home Phone | Cell Phone

Employer
Address | City | State | Zip | Business Phone

Insurance
Company | Group number | Policy/subscriber number | Phone number | Contact person

Spouse ⊥
Names of other dependents covered under this policy

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay 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 for the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. My insurance will be billed as a courtesy and it is my responsibility to notify the office of any changes that occur. My insurance policy is a contract between myself and the insurance company.

Signature _____ Date _____

HEALTH INFORMATION PRIVACY ACT ACKNOWLEDGEMENT (HIPAA)

I have been informed of the guidelines of the HIPAA Privacy Act and have access to read and/or receive a copy.

Patient Name (Please print) | Patient/Parent/Guardian Signature | Date