Patient Information Form

Personal Information:

Last Name:	First Name:	Middle Initial:
DOB:	Age:	Social Security Number:
Address:		
City:	State:	Zip Code:
Wireless Phone:	Home Phone:	E-mail:

Primary Insurance Information:	Secondary Insurance Information:
Insurance Carrier:	Insurance Carrier:
Insurance Carrier Phone:	Insurance Carrier Phone:
Employer:	Employer:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Member ID:	Member ID:
DOB:	DOB:
Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child	Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Emergency Contact Information:

Name of Contact:
Phone Number:
Relationship to Patient:
May we communicate information with this individual concerning your care? ☐ Yes ☐ No

Physician and Pharmacy Information:

Physician Name:	Phone Number:
Street Address:	City/State/Zip Code:
Date of Last Visit:	
Reason for Last Visit?	
Pharmacy Name:	Phone Number:
Street Address:	City/State/Zip Code:

Dental Information:

Prior Dentist Name:	
Date of Last Visit?	Date of Last X-rays?
Reason for Today's Visit:	

Authorization:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any of my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I am agreeing to responsibility of services not paid in full or part by my dental care payer.

I attest to the accuracy of the information on this page.

Patient or Guardian Signature Date