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Set the course for your oral health

Welcome

We are please to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your periodontal health.

PATIENT INFORMATION

Today's date _____

Name _____ I prefer to be called _____

Sex M ☐ F ☐ Age _____ Birthdate _____ Regular Dentist _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Email _____

Employed by _____ Work Phone _____

How do you want to be contacted? Cell Phone ☐ Home Phone ☐ Text ☐ Can we leave a message? Yes ☐ No ☐

Notify in case of Emergency _____ Emergency Phone _____

Who may we thank for referring you? _____

PRIMARY DENTAL INSURANCE

Subscriber *(if different than above)* _____

Relation to patient _____ Birthdate _____

Subscriber Employer _____

Insurance Company _____

Insurance Address _____

_____

Insurance Phone _____

Subscriber # _____

Group # _____

ADDITIONAL DENTAL INSURANCE

Subscriber _____

Relation to patient _____ Birthdate _____

Address *(if different than patient)* _____

City _____ State _____ Zip _____

Subscriber Employer _____

Insurance Company _____

Insurance Address _____

Subscriber # _____

Group # _____

AUTHORIZATION

I have reviewed the information on this questionaire, 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 are any changes in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsibile for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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