Patient Information Form

____ What name shall we call you? ____________________

Patient: (Last) *(First)* *(Middle initial)*

Date of Birth ____--____--____ Social Security #(or ID#)___________________ Email __________________________

Home Phone____________ Cell Phone________________ Work Phone____________________

Which is the best number to reach you during the day? *home cell work* May we contact you at work ? *yes no*

Home Address____

(Street) *(City)* *(State)* *(Zip code)*

Employer______________________ Occupation_____________ Do you have dental insurance?

Insurance carrier_________________________________ Group or policy number__________________________

Spouse name________________________________ Birthdate ____--____--____ SSN_______--_______--_______

Spouse Employer____ Spouse Work Phone ________________

Secondary insurance carrier_____________________________________ Group or policy number______________

Parent (if patient is a minor)_____________________ Birthdate ____--____--____ SSN_______--_______--_______

Person to contact in case of an emergency__________________________________ Telephone_________________

*WHO MAY WE THANK FOR REFERRING YOU?*____

To avoid any misunderstanding regarding your dental insurance, we wish our patients to know that all **professional services rendered are charged directly to the patient and that the patients are ultimately responsible for payment of fees.** We do not render services on the basis that the insurance companies will pay our fees unless a written predetermination of benefits has been established. We will assist you in filing all insurance forms. **Payment is due when service is rendered unless other arrangements have been made.** If insurance is involved, we ask that you pay your estimated portion of any dental treatment the day services are rendered. We can only estimate what your portion may be. **If there is a difference between your estimated portion and what your insurance pays, you are responsible for the balance.**

I hereby authorize Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of medication, and therapy that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatment or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. I understand that responsibility for payment of dental service provided in this office for me or my dependents is mine, due and payable at the time services are rendered.

Signature of patient or responsible party ____________________________________ **Date** __________________