



### PATIENT INFORMATION

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_ Sex \_\_\_\_\_  
Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Bus. phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Soc. Sec. No. \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency contact person \_\_\_\_\_ Phone \_\_\_\_\_

### ACCOUNT INFORMATION

Person above is responsible for account.

Preferred Method of Payment: Cash \_\_\_\_\_ Check \_\_\_\_\_ Visa/MC \_\_\_\_\_

Persons responsible for Account Payment: Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

### INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Insured SSN: \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_

Primary Ins. Carrier Co. \_\_\_\_\_ Ins. Co. Phone \_\_\_\_\_

Group # \_\_\_\_\_ Policy# \_\_\_\_\_ Employer Name \_\_\_\_\_

Date Employed \_\_\_\_\_ Employer address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Date Employed \_\_\_\_\_

Dual Coverage? No \_\_\_\_\_ Yes \_\_\_\_\_ If Yes Secondary Ins. Co. \_\_\_\_\_

Ins. Co. Phone \_\_\_\_\_ Group # \_\_\_\_\_ Policy# \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Date Employed \_\_\_\_\_

I authorize the release of any information necessary to process my insurance claim. I also authorize payment to the Dentist of the insurance benefits otherwise payable to me. A copy of this signature is valid as original.

X \_\_\_\_\_