How did you hear
About us? ____

Name____
Last First Middle Initial Nickname

Address____
Street

____
_ City State Zip

Employer_______________________ Social Security #___________________________

Birth date_______________________

Phone (home) ____________________ (Work) ____________________

(Cell) ____________________ Male Female Marital Status__________

(E-mail)____________________ Emergency Contact: Name/Number____________________

Insurance

Primary dental Carrier

Subscriber Name____________________ Social Security #______________ DOB________

Employer_______________________ Insurance Co.___________________________

Insurance Co. Phone #________________ Group #______________________________

Insurance Co. Address____

Secondary Dental Carrier

Subscriber Name____________________ Social Security #______________ DOB________

Employer_______________________ Insurance Co.___________________________

Insurance Co. Phone #________________ Group #______________________________

Insurance Co. Address____

Insurance Authorization Statement (Sign & Date)

I hereby authorize the dental office to file my insurance claims, and authorize insurance payments to directly be sent to the dental office for my benefit. I understand that I am responsible for all cost and dental treatment. I understand that I am also responsible for the difference of the portion that the insurance company may deny, or reduce/downgrade with the associated dental treatment. The information on this page and the medical history is correct to the best of my knowledge.

Signature____ Date________________________________