Date_____ **PATIENT INFORMATION**

Name_____
Last **First** **M. I.**

Address_____

City_____**State**_____**Zip**_____

Date of Birth____/____/____ **Social Security #** _____-_____-_____

Name of Spouse (if applicable)_____

Home Phone #_____ **Cell Phone #**_____

Employer_____ **Work Phone #**_____

Person Responsible for account_____**Relationship**_____

Address_____**State**_____**Zip**_____

Referred by_____

PRIMARY DENTAL INSURANCE INFORMATION (if applicable)

Name of Subscriber _____**Relationship to Patient**_____

Subscriber's Employer _____**Subscriber's Birthday**___/___/____

Subscriber's SS# or Insurance ID #_____

Dental Insurance Company _____**Group #**_____

Address_____**City**_____**State**____**Zip**_____

SECONDARY DENTAL INSURANCE INFORMATION (if applicable)

Name of Subscriber _____**Relationship to Patient**_____

Subscriber's Employer _____**Subscriber's Birthday**___/___/____

Subscriber's SS# or Insurance ID #_____

Dental Insurance Company _____**Group #** _____

Address_____**City**_____**State**____**Zip**_____

ASSIGNMENT OF BENEFITS

I authorize payment of benefits to the dentist for services rendered.
Signature (Insured of Authorized Person) _____Date_____

RELEASE OF INFORMATION

I authorize the dentist or insurance company to release any information required for payment or review of dental claims. I am financially responsible to the dentist for any balance due.
Signature (Patient or parent or guardian of minor)_____Date____-_____