PATIENT INFORMATION CONFIDENTIAL

Welcome to THE DENTAL PEOPLE!

Date:_____

NAME:_____
First Middle Last

If child, name of parents/guardian:
Mother: _____ Father: _____ Guardian: _____

If married/separated/ has domestic partner, name of spouse/partner:_____

ADDRESS:_____
Street City State Zip

BIRTHDAY:_____ AGE:_____

✓ Check the appropriate status: ___ Minor ___ Married ___ Single ___ Has domestic partner
___ Widowed ___ Divorced ___ Separated

Are you a student: Yes No If yes, Name and Address of School:_____

PHONE NUMBER AND EMAIL ADDRESS

Home:_____ Work:_____

Cell:_____

Email:_____

What is your preferred way to confirm you appointments?

Cell # Work # Home # E-mail

What is the Best time to call?_____

✓ In the Event of an Emergency, whom should we contact?

Name:_____

Relationship:_____

Phone:_____

How did you hear about our office? (You can check more than one).

___Yelp ___Internet ___Website ___Search Engine (ex: google, yahoo)

___Insurance: which one? _____ ___Family Member: which one? _____

___Friend: Name of friend _____ ___Other:_____

Responsible Party

Name of the person responsible for this account:_____ Occupation: _____

Relationship to patient:_____ Employer:_____ Birthday:_____

Driver's license#:_____ Soc.Sec #:_____ Tel #:_____

Address:_____
Street City State Zip

Is this person currently a patient in our office? Yes No

PRIMARY INSURANCE

Name of Insured:_____ Relationship:_____ Birthdate: _____ SS#: _____

Employer:_____ Work Phone:_____ Date employed:_____

Address of employer:_____
Street City State Zip

Insurance Company:_____ Group #:_____ ID #:_____

Insurance Co. Address:_____

How much is your deductible?_____ What is the Maximum Annual Benefit?_____

SECONDARY INSURANCE

Do you have secondary Insurance? Yes No If yes, complete the following:

Name of insured:_____ Relationship:_____ Birthdate:_____ SS#: _____

Employer:_____ Work Phone:_____ Date Employed:_____

Address of employer:_____

Insurance Company:_____ Group #:_____ ID#:_____

Insurance Co. Address:_____

How much is your deductible?_____ What is your Maximum Annual Benefit?_____

Finance

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment.
Please check the option that you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

- ❑ Cash
- ❑ Personal Check
- ❑ Credit Card
- ❑ Visa
- ❑ Mastercard
- ❑ Payment Plan

Card #:_____

Expiration Date:_____

Authorization, Release, & Agreement to Pay for Services Rendered

I Authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care, to third party payers and/or health practitioners.

I Authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____
Signature of patient (or parent, if minor)

Confirmation calls for appointments will be made to phone numbers you have listed. I authorize the dental team to leave messages at my home or cell phone number for exam and cleaning appointment reminders.

Signature of patient: (or parent, if minor)_____ Date: _____