PATIENT INFORMATION FORM

Patient Name:________________________________ Nickname:_________________ Sex: _____ Birthdate: ____/____/____

Home Address:____

(Street Address, City, State, Zip Code)

Social Security Number: __________________________ Email Address:____

Referred by: (name)_____________________________ (address)____

Is your child covered by dental insurance? ❐ YES ❐ NO

Emergency Contact:____________________________________ Relationship: ______________________________________

Home Address: ____________________________________ Work Address: _____________________________________

____________________________________ Cell Phone: _____________________________________

Home Phone: _____________________________________ Work Phone: _____________________________________

Father

Father's Name:____________________________________

Birthdate: _____/_____/_____

Social Security Number: _____________________________

Employer: ______________________________________

Occupation: _____________________________________

Home Address: ____________________________________

____

Home Phone: _____________________________________

Cell Phone: _____________________________________

Work Phone: _____________________________________

Mother

Mother's Name:____________________________________

Birthdate: _____/_____/_____

Social Security Number: _____________________________

Employer: ______________________________________

Occupation: _____________________________________

Home Address: ____________________________________

____

Home Phone: _____________________________________

Cell Phone: _____________________________________

Work Phone: _____________________________________

Financially Responsible Party – (If Mother or Father, enter "Mother" or "Father")

Name: ____ Birthdate: _____/_____/_____

Social Security Number: ______________________________ Employer:____

Home Address: ____________________________________ Work Ph: ________________Cell Ph:________________

____________________________________ Home Phone: _____________________________________

Primary Insurance Information

Name of Plan: ____________________________________

Group Number: ____________________________________

Address: ____

____

Subscriber's Name: ________________________________

Phone: ____

Secondary Insurance Information

Name of Plan: ____________________________________

Group Number: ____________________________________

Address: ____

____

Subscriber's Name: ________________________________

Phone: ____

Form of Payment Preferred: ❐ Cash ❐ Check ❐ Credit Card

Statement of Financial Responsibility

I have read and understand the "Practice Financial Policy" and agree to abide by its terms. If I have insurance coverage, I understand that your office will file my insurance claim at no cost to me. However, I understand that I am financially responsible for the cost of dental treatment. If this account is sent to a collection agency, I also understand that I will be responsible for the account balance, as well as any reasonable attorney and collection fees incurred in the effort to collect my account balance.

Signature: ____ Date: ______/______/______