**PATIENT INFORMATION**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name | | First Name | | | | Preferred Name | | |
| Birth Date | SS# | | | Home Phone | | | Cell Phone | |
| Mailing Address | | | City | | State | | | Zip Code |
| E-mail | | | | Referred By | | | | |

**RESPONSIBLE PARTY INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name | First | | Relationship to Patient  \_\_\_Self \_\_\_Spouse \_\_\_Child  \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Home Address | | City | | State | Zip Code |

**PRIMARY DENTAL INSURANCE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Insurance Company | Phone # | | ID/SS# of Subscriber | | Group # |
| Subscribers Name | | Birth Date | | Relationship to Patient  \_\_\_Self \_\_\_Spouse \_\_\_Child | |

**SECONDARY DENTAL INSURANCE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Insurance Company | Phone # | | ID/SS# of Subscriber | | Group # |
| Subscribers Name | | Birth Date | | Relationship to Patient  \_\_\_Self \_\_\_Spouse \_\_\_Child | |

I agree that all of the above information is correct to the best of my knowledge. I understand that my dental insurance may pay less than their estimate portion for services. I agree to be responsible for payment of all services rendered on my behalf / behalf of my dependents.

Signature (patient, parent or guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_