**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: \_\_\_\_\_\_\_\_\_\_\_\_