

Insurance Information

Insurance Company _____ Name of Insured _____

DOB _____ Social Security # _____ Date of employment _____

Employer _____ Group # _____

Relationship to patient (circle one) Father Mother Child Husband Wife

Do you have additional insurance? Yes No If yes, please complete the following:

Insurance Company _____ Name of Insured _____

DOB _____ Social Security # _____ Date of employment _____

Employer _____ Group # _____

Relationship to patient (circle one) Father Mother Child Husband Wife

Must complete if under 18 or a full time student

Mother's Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

DOB _____ Cell Phone # _____ Home Phone # _____

Employer _____ Work Phone # _____

Father's Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

DOB _____ Cell Phone # _____ Home Phone # _____

Employer _____ Work Phone # _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records for any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or 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 and any collection fees accumulated on my behalf or that of my dependents.

X _____
Signature of Patient (or parent if a minor)

Date _____

Medical Updates

Please review medical history and make any changes necessary. Thank you for your cooperation.

Date _____ Patient Signature _____

Date _____ Patient Signature _____

Date _____ Patient Signature _____

Date _____ Patient Signature _____