Date ____________

**Whom may we thank for referring you?** ______________________________

First Name ____________ Last Name ____________ Middle Initial ____

Patient Is ☐ Policy Holder ☐ Responsible Party  Preferred Name ____________

## Responsible Party ( if someone other than the patient )

First Name ____________ Last Name ____________ Middle Initial ____

Address ____________ Address 2 ____________

City, State, Zip ____________

Home Phone ____________ Work Phone ____________ Ext ______ Cell ____________

Birth Date ____________ Soc Sec ____________ Drivers Lic ____________

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

## Patient Information

Address ____________ Address 2 ____________

City ____________ State / Zip ____________

Home Phone ____________ Work Phone ____________ Cell ____________

Sex ☐ Male ☐ Female  Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date ____________ Age ______ Soc Sec ____________ Drivers Lic ____________

E-mail ____________ I would like appointment reminders via E-mail ☐ Text ☐

### Section 2

Employment Status ☐ Full Time ☐ Part Time ☐ Retired

Student Status ☐ Full Time ☐ Part Time

Medicaid ID ____________ Pref. Dentist ____________

Employer ID ____________ Pref. Pharmacy ____________

Carrier ID ____________

### Section 3

Emergency Contact ____________

Emergency Phone # ____________

Relationship ____________

OK to phone @ work? ____________

Employer ____________

48 Notice ____________

## Primary Insurance Information

Name of Insured ____________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec ____________ Insured Birth Date ____________

Employer ____________ Ins. Company ____________

Address ____________ Address ____________

Address 2 ____________ Address 2 ____________

City, State, Zip ____________ City, State, Zip ____________

Rem. Benefits ____________ Rem. Deduct ____________

## Secondary Insurance Information

Name of Insured ____________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec ____________ Insured Birth Date ____________

Employer ____________ Ins. Company ____________

Address ____________ Address ____________

Address 2 ____________ Address 2 ____________

City, State, Zip ____________ City, State, Zip ____________

Rem. Benefits ____________ Rem. Deduct ____________

***ASSIGNMENT AND RELEASE***

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____________________ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________ Responsible Party Signature ______________________ Relationship __________ Date