DENTAL USA
FAMILY DENTISTRY

PATIENT INFORMATION

Date _____

Name _____ Sex: M ___ F ___ Birthdate ___/___/___

Social Security # _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Driver License # _____

When confirming appointments how do you prefer to be contacted? ___Phone ___Email ___Text Message

Patient or Parent Employer _____ Work Phone _____

May we contact you at work? _____ Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

In case of emergency who should be notified? _____ Phone _____

How did you hear about our office? (Check all that apply)

___Google ___Website ___Yellow Pages ___Drive By ___Insurance Listing ___Other

Friend _____ Patient _____

PRIMARY INSURANCE

Person Responsible for Account _____ Relation to Patient _____

Employer _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents covered under this plan _____

DENTAL HISTORY

Name of Previous Dentist/Location _____ Date of Last Exam/Cleaning _____

What would you like to change about your smile? _____

OFFICE POLICIES

I understand that payment is expected at time services are rendered. If I have dental insurance, I authorize payment directly to the doctor all insurance benefits, if any, otherwise payable to me for services rendered. I understand that deductibles and copays are due on the date of service. The office does its best to give me the most accurate estimate of my benefits. I know that insurance companies do not guarantee benefits over the telephone. I understand that I am responsible for knowing the coverage and benefits of my insurance policy. If my insurance company does not pay my claim as expected, I understand that the responsible party is obligated for the balance of the account. I understand that if my account must get turned over to a collection agency that I am responsible for a $30.00 late fee.

Signature of Patient or Parent if Minor _____ Date _____