Patient Information

Name _____

Home address _____ **Town** _____

Home phone # _____

Cell phone # _____

Date and year of birth _____

Social security number _____

For what company do you work? _____

Business address _____

Business phone # _____

Occupation _____

If married for what company does spouse work _____

Spouse's business phone _____

Spouse's occupation _____

Who referred you to this office? _____

Do you have a dental insurance plan? _____

If yes, does a second dental insurance policy cover family? _____

Are there any questions you would like answered? _____

I hereby authorize the above named dentist to provide any insurance company, claim administrator, health professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administrating claims for benefits. I hereby authorize payment directly to the dentist

Signature _____ **Date** _____