PATIENT INFORMATION FORM

Patient Name: _____ Sex: _____ Birthdate: _____

Nickname: _____ Email: _____

Home Address: _____
(Street address, City, State, Zip Code)

Referred by: (Name) _____ (address) _____

Is your child covered by dental insurance? ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____

Home Address: _____ Work address: _____

_____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Father

Father's Name: _____

Birthdate: _____

Social Security Number: _____

Employer: _____

Occupation: _____

Home Address: _____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Mother

Mother's Name: _____

Birthdate: _____

Social Security Number: _____

Employer: _____

Occupation: _____

Home Address: _____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Finacially Responsible Party- (if Mother or Father, enter "Mother" or "Father")

Name: _____ Birthdate: _____

Social Security Number: _____ Employer: _____

Home Address: _____ Work Phone: _____ Cell: _____

Home Phone: _____

Primary Insurance Information

Subscriber Name: _____

Name of Plan: _____

Subscriber ID: _____

Group#: _____

Plan Address: _____

_____

Secondary Insurance Information

Subscriber Name: _____

Name of Plan: _____

Subscriber ID: _____

Group#: _____

Plan Address: _____

_____

Form of Payment Preferred: ☐ Cash ☐ Check ☐ Credit Card

Statement of Financial Responsiility

I have read and understand the "Practice Financial Policy" and agree to abide by its terms. If I have insurance coverage, I understand that your office will file my insurance claim at no cost to me. However, I understand that I am financially responsible for the cost of dental treatment. If this account is sent to a collection agency, I also understand that I will be responsible for the account balance, as well as any reasonable attorney and collection fees incurred in the effort to collect my account balance.

Signature: _____ Date: _____