Patient Information Sheet

Name: _____
(Last) (First) (MI) (Date of Birth) (sex)

Home Address: _____
(Street) (Apt #) (City) (State) (Zip)

Mailing Address: _____
(if different from above)

Social Security #: **Employer:** **Occupation:**

Home Phone: **Cell Phone:** **Work Phone:**

Referred by General Dentist:

Spouse or Parent Name: _____
(Last) (First) (MI) (Date of Birth) (sex)

Address: _____
(if different than above) (Street) (Apt #) (City) (State) (Zip)

Occupation: **Employer:**

Home Phone: **Cell Phone:** **Work Phone:**

Dental Insurance Co.: **Phone:**

Address: **Group #:**

Social Security Number OR **Insurance ID Number:**

Secondary Dental Insurance Co: **Phone:**

Address: **Group #:**

Social Security Number OR **Insurance ID Number:**

Financial Consent:

If this office is able to accept your insurance company's assignment of benefits, your claim will be submitted after treatment is rendered. Please provide us the necessary information for your plan. The **estimated** co-payment amount provided by this office is considered **a guideline only** and is due at the time of service. This office can make no guarantee of payment as estimated.

"I understand that I am responsible for payment of services rendered and responsible for paying any charges my insurance does not cover. I am also responsible for any additional fees if this account is turned over for collection."

Method of Payment Today: **Signature:**

Privacy Notice:

This office's privacy practices are in accord with HIPAA regulations. You may obtain a copy of our privacy practices at any visit. Your signature here indicates that you have been advised of the availability of this information.

Signature: **Date:**