Patient Information

Today's Date_____ Patient's Birthdate_____ Social Security # ____-____-____ DL #_____

Patient's Name_____
Last First Middle Name you prefer to be called

Physical Address_____ E-mail address_____
Street City State Zip Code

Home Phone_____ Work Phone_____ Cell Phone_____

Patient's Employer_____ Occupation_____ No. of Years Employed_____

If Patient is a minor, give parent's or guardian's name_____

Name of nearest relative ***not living with you***_____

Relationship to patient_____ Address_____ Phone_____

Are you having any problems with your teeth?_____ If so, what?_____

When and where did you have your last dental exam and dental x-rays?_____

Are you interested in a whiter, brighter smile?_____

What are your hobbies or special interests?_____

Whom may we thank for referring you to our office?_____

_____

Account Information
(Person ultimately responsible for account)

Name_____ Relationship to Patient_____
Last First Middle

Billing Address_____
Street City State Zip Code

How long at this address?_____ Previous address (if less than 3 yrs.)_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____ Occupation_____ No. of Years Employed_____

Birthdate_____ Social Security #_____-_____-_____

Spouse's Name_____ Spouse's Employer _____

Spouse's Occupation_____ Spouse's Work Phone_____ Spouse's Cell Phone_____

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Dental Insurance Information

Primary Dental Insurance:
Insured's Name_____ Relationship to Patient_____ Insured's Employer_____

Insured's Social Sec. #___-____-_____ Insured's Birthdate_____ Insurance Company Name_____

Group #_____ Ins. Co. Phone #_____Insurance Company Address_____

Secondary Dental Insurance:

Insured's Name_____ Relationship to Patient_____ Insured's Employer_____

Insured's Social Sec. #_____-____-_____ Insured's Birthdate_____ Insurance Company Name_____

Group #_____ Ins. Co. Phone #_____Insurance Company Address_____

I hereby authorize release of information to my insurance company and authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I understand that most dental insurance policies provided coverage based on "usual, customary, and reasonable fees, or UCR." (UCR is set by the insurance company. I understand that Pampa Dental Arts' fees are not determined in cooperation with insurance companies and that he and his staff have no control over what my policy will pay. I fully understand I am solely responsible for any balance not paid by my insurance company. Disputes as to coverage, payments, or eligibility are strictly between me and my insurance carrier.

*Signature*_____ *Date*_____