

Date \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Patients Name	Date of Birth	Social Security#

Address	City	State	Zip	Home Phone#

Employer name and address:	Business Phone#

If Child, Parent's or Guardian's Name	Cell Phone#

Do you have dental insurance?	E-Mail address:
Yes No	

Subscriber's Name	Date of Birth	Social Security#

Subscriber/Policy#	Relationship to Subscriber
	Self Spouse Child Other

Subscriber's Employer name & address

Dental Insurance company name, address & phone#

Do you have Secondary Insurance?	Yes No
----------------------------------	--------

Subscriber's name	Date of Birth	Social Security#

Subscriber/Policy#	Relationship to Subscriber
	Self Spouse Child Other

Subscriber's Employer	Insurance Company name, address & phone#

I authorize this office to release any information necessary to expedite insurance claims.  
I understand that I am responsible for all charges, regardless of insurance coverage.

\_\_\_\_\_  
Patient, Parent, or Guardian Signature

\_\_\_\_\_  
Date