

PATIENT INFORMATION

Name: _____
(Last) (First) (MI)

Mailing Address: _____

(City) (State) (Zip)

Date of Last Exam: ____/____/____ Male Female

Social Security Number: _____-_____-_____

Marital Status: Single Married Divorced

IN CONTACT 📞

Home Phone: (____) _____

Mobile Phone: (____) _____

Work Phone: (____) _____

E-mail Address

DENTAL INSURANCE INFORMATION *(Primary Dental Insurance)*

Policy Holder's Name: _____

Relationship to the patient: _____

Address same as above

Policy Holder's DOB: ____/____/____

Address: _____

(City) (State) (Zip)

Policy Holder's

Social Security Number: _____-_____-_____

Employer: _____

Insurance Co.: _____

Address: _____

Ins. Co. Phone No.: (____) _____

(City) (State) (Zip)

Member ID: _____

Group No.: _____

Employer Phone Number: (____) _____

Referral Information

Whom may we thank for referring you? Another patient Direct Mail Newspaper Internet/Website Other

Name of the person referring you to our practice: 😊 _____

- I understand, the information given in this form, is necessary to provide me and/or my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the dentist of any change in my health or medication.
- I have read, signed and agree to the FAMILY FIRST DENTAL CENTER **Financial Agreement**. (Signed copy in chart)
- I authorize and request that my insurance company pay directly to FAMILY FIRST DENTAL CENTER all benefits otherwise payable to me or on behalf of a family member.
- I authorize the dentist to release any information including the diagnosis and the records of any treatments or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I understand that FAMILY FIRST DENTAL CARE complies with all HIPAA policies and regulations. I am aware that The Notice of Privacy practices is posted in the dental office.

✗ Parent/Guardian: _____ Relationship: _____ Date: _____
(Signature)

✗ Guarantor of payment/responsible party: _____ Relationship: _____
(Signature)