Dimples

Dimples Family Dentistry

Date: _____

Patient Information

Patient's Full Name _____ Nickname _____
SSN _____ Date of Birth _____ Age_____
Male/Female (circle one) Marital Status_____
Home Address _____ Home Phone _____
City _____ State _____ Zip Code _____ Cell Phone _____

Employer _____ Occupation_____
Work Address _____ Work Phone_____
May We Contact Your Work Phone? _____

Spouse Information

Spouse's Name _____ Spouse's SSN _____
Spouse's Date of Birth _____ Spouse's Employer _____

Emergency Contact (person not living with you) _____
Relationship_____ Phone Number _____
Family Physician's Name _____ Physician's Phone # _____

How Did You Hear About Our Office? _____

Responsible Party for Payment of Account

The responsible party must be present to sign this section. We cannot list someone other than yourself if that person is not with you today. Thank You.

Name of Responsible Party _____ Relationship _____
Home Address _____ SSN _____
_____ Phone Number _____
Date of Birth _____ Employer _____
Occupation _____ Employer Address _____
Length of Employment _____ Work Number _____

Signature of Responsible Party _____

Insurance Information

Please provide the following information for insurance purposes. We will be happy to file your insurance claims for you as a courtesy, however, **we do require a copy of your insurance card, if you do not have an insurance card, please fill out the information below.**

Primary Dental Insurance Company

Insurance Company _____ Group # _____
Subscriber's Name _____ Date of Birth _____
Home Address _____
Home Phone _____ Work Phone _____
Employer _____

Secondary Dental Insurance Company

Insurance Company _____ Group # _____
Subscriber's Name _____ Date of Birth _____
Home Address _____
Home Phone _____ Work Phone _____
Employer _____

If accident related, please indicate where, when and how the accident occurred _____

_____

Worker's Compensation Information _____

Assignment of Insurance Benefits

I hereby assign any and all insurance benefits to be paid directly to Dimples Family Dentistry.

Patient Signature _____ Date _____
(If patient is a minor, parent or guardian signature is required)

Dimples Family Dentistry Financial Policy

It is our policy to collect payment at the time of services rendered. You are responsible for your account within the limits of our credit policy regardless of insurance coverage. If you provide your insurance information, we will be glad to file your insurance as a courtesy for you. All balances due, after receipt of your insurance carrier's payment, are payable within 30 days of statement due.

Patient Signature _____ Date _____
(If patient is a minor, parent or guardian signature is required)