PATIENT:

(Dr., Mr., Mrs., Ms.)_____
FIRST MI LAST

Date of Birth _____ Soc. Sec. No. _____

Home Address _____

_____
CITY STATE ZIP

Home Phone _____ Work/Cell Phone_____

Marital Status _____ If a student ☐ Full Time ☐ Part Time School _____

E-mail: _____ Who has referred you? _____

Physician: _____ Physician Phone: _____

Who will be responsible for your account?

Name: _____ Relationship to patient_____

Address: _____
(if different from above) CITY STATE ZIP

Insured Party Name: _____

Address: _____
(if different from above) CITY STATE ZIP

Home Phone: _____ Work/Cell Phone: _____

Date of Birth: _____ SSN: _____

Insurance Co: _____

Address: _____
CITY STATE ZIP

Employer: _____ Occupation: _____

Policy ID# _____

Group #: _____

AUTHORIZATION OF INSURANCE BENEFITS:

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named on the insurance benefits otherwise payable to me.

Signature of Patient/Guardian _____ **Date:** _____

Signature of Guarantor _____