

PATIENT INFORMATION FORM

Patient Name: _____		Sex: _____	Birthdate: _____
Nickname: _____		Email: _____	
Home Address: _____			
<small>(Street address, _____)</small>		<small>City, _____</small>	<small>State, _____</small>
Referred by: (Name) _____		(address) _____	
Is your child covered by dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Emergency Contact: _____	Relationship: _____
Home Address: _____	Work address: _____
_____	Cell Phone: _____
Home Phone: _____	Work Phone: _____

<u>Father</u>	<u>Mother</u>
Father's Name: _____	Mother's Name: _____
Birthdate: _____	Birthdate: _____
Social Security Number: _____	Social Security Number: _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____
Home Address: _____	Home Address: _____
_____	_____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____

Financially Responsible Party- (if Mother or Father, enter "Mother" or "Father")	
Name: _____	Birthdate: _____
Social Security Number: _____	Employer: _____
Home Address: _____	Work Phone: _____ Cell: _____
_____	Home Phone: _____

Primary Insurance Information	Secondary Insurance Information
Subscriber Name: _____	Subscriber Name: _____
Name of Plan: _____	Name of Plan: _____
Subscriber ID: _____	Subscriber ID: _____
Group#: _____	Group#: _____
Plan Address: _____	Plan Address: _____
_____	_____

Form of Payment Preferred: Cash Check Credit Card

Statement of Financial Responsibility	
<p>I have read and understand the "Practice Financial Policy" and agree to abide by its terms. If I have insurance coverage, I understand that your office will file my insurance claim at no cost to me. However, I understand that I am financially responsible for the cost of dental treatment. If this account is sent to a collection agency, I also understand that I will be responsible for the account balance, as well as any reasonable attorney and collection fees incurred in the effort to collect my account balance.</p>	
Signature: _____	Date: _____