# Patient Information Form

Date of Appointment: _____ Doctor: _____

(Please complete and return to receptionist)

NAME: Last First, Middle [ ] Male [ ] Female TODAY'S DATE

_____

ADDRESS: Street or PO Box City State Zip

_____

PHONE NUMBERS: Daytime Nighttime Other E-Mail Address

_____

DATE OF BIRTH [ ] Single [ ] Married SOCIAL SECURITY NO.

_____

OCCUPATION EMPLOYER PHONE NUMBER

_____

UNION & LOCAL

_____

## Insurance Information

INSURED PERSON'S FULL NAME DATE OF BIRTH

_____

SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT WORK PHONE

_____

INSURANCE COMPANY NAME PLAN/GROUP #

_____

EMPLOYER FULL ADDRESS OF INSURANCE COMPANY

_____

DO YOU HAVE OTHER DENTAL INSURANCE? INSURED PERSON'S FULL NAME

_____

DATE OF BIRTH ADDRESS

_____

RELATIONSHIP SOCIAL SECURITY NO.

_____

OCCUPATION EMPLOYER PHONE NUMBER

_____

## Getting To Know You

1. Where did you see/hear about us?
   - [ ] Union Letter _____
   - [ ] Union Office Counter/Representative _____
   - [ ] Family Member (Name) _____
   - [ ] Website (Circle One): -Dental Source Website -Your Union Website -Internet Search -Radio - Deal Snapt
   - [ ] Other _____
2. Is another member of your family or relative a patient in our practice? _____
3. Closest Living Relative: _____

   Relationship: _____ Phone: _____

_____

If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage your particular plan provides. We accept assignment of your insurance payment, another service to you. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

## For All Patients

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls, texts, and appointment reminder items sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office.

_____

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE