

## 1 one

### ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Employer:** \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No How many? \_\_\_\_\_

### Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name \_\_\_\_\_  
(Please Print)

Signature \_\_\_\_\_

Birthdate \_\_\_\_\_

Date \_\_\_\_\_  
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## two

### INSURANCE INFO

#### Primary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

#### Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

## three

### ACCOUNT INFO

#### Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SS #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

**Payment method:**  Cash  Check

Credit Card - Enter card # above (if accepted) \_\_\_\_\_

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

## four

### IN EVENT OF EMERGENCY

Whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Medical Doctor's Phone #: (\_\_\_\_) \_\_\_\_\_

PLEASE CONTINUE ON BACK