

Patient Information

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Date of Birth: _____ Sex: Male Female Marital Status: Single Married Divorced Widowed Separated

Social Security #: _____ Driver License #: _____ State: _____

Occupation: _____ Employer: _____

Student (IF OVER 18): Fulltime Partime

Billing Information

(ONLY IF PATIENT IS A MINOR)

Last Name: _____ First: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____

Dental Insurance

(POLICY HOLDER'S INFO)

Policy Holder's Name: _____ Date Of Birth: _____ Relationship to Patient: _____

Social Security #: _____ Member ID(if applicable): _____ Group #: _____

Insurance Company: _____ Phone #: _____

Employer: _____ Group #: _____

Authorization

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO AND HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE BAYABLE TO ME.

_____ SIGNED (Patient or parent if minor) _____ SIGNED (Insured Party) _____ DATE _____

Physician's Name: _____ Previous Dentist's Name: _____

Name & Address of nearest living relative: _____

Is any other family member a patient in our office? If so, patient's name: _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? _____

HOW DID YOU HEAR ABOUT DAVID & ASSOCIATES?

Referred by a patient. Patient's Name: _____ TV
 Referred by an employee. Name: _____ Radio
 Direct Mail. What type: _____ Internet
 Brochure Yellow Pages
 Newspaper Other