

Patient Information

Patient Information

Name			
Birth / SSN / License			
Gender	Female: []	Male: []	
Marital Status	Single: []	Married: []	Divorced: []
	Separated: []	Widowed: []	

Patient Contact Information

Address

Phone

Email

Responsible Party

Responsible Party refers to the person that is Financially Responsible for the patient (Guarantor).

Who is the Responsible Party	Self: []	Another Person: []
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Responsible Party Information

Responsible Party Name

Birth / SSN / License

Responsible Party Contact Information

Address

Email

Phone

For your convenience, our office can communicate with you about your health and our office by email and text message.

It's ok for our office to communicate with you by text message Yes [] No []

It's ok for our office to communicate with you by email Yes [] No []

Insurance Information

Insurance Type

Do you have dental insurance or will you be paying for yourself?

Primary Dental Insurance - Insurance Company

PATIENT INFORMATION

Patient: Submitted: 8/29/2025

Type of Plan
Insurance Company Name
Subscriber ID
Group #

Primary Dental Insurance - Insured

Relationship to Patient
Name
DOB / SSN / License
Address

Secondary Dental Insurance - Insurance Company

Do you have secondary insurance you'd like to use? Yes [] No []
Type of Plan
Insurance Company Name
Subscriber ID
Group #

Secondary Dental Insurance - Insured

Name
Relationship to Patient
DOB / SSN / License
Address

Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. (Read Electronic Record and Signature Disclosure)

I consent to use Electronic Records and Signatures: []