Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. If you have any questions please don't hesitate to ask.

Patient Name:_____Today's Date_____

Social Security No._____ Date of birth_____Age_____Sex_____

Driver's license No._____State_____

Employer/occupation_____Business phone_____

Spouse's name_____Spouse's phone_____

Primary dental insurance_____Group No._____

Subscriber's name_____Employer _____

Subscriber ID # _____ Date of Birth _____

Secondary dental insurance_____Group No._____

Subscriber's name _____Employer_____

Subscriber ID # _____ Date of Birth _____

Patient Information

Authorization

I certify that I and/or my dependent(s) have insurance coverage with_____

And assign directly to Parkland Pacific Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above –named dental office may use my health care information and my disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Date:_____

(*Signature of Patient, Parent, Guardian or Personal Representative*)

_____Reltationship_____

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