

Today's Date: ____ / ____ / ____



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About You

Patient Name: _____

What you prefer to be called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: _____ SS#: _____

Mailing Address: _____

CITY STATE ZIP CODE

Home Phone #: _____

Work Phone #: _____ Other Phone #: _____

E-mail: _____

Would you prefer e-mail confirmations for your dental appointments? Yes No

Please check all the ways you heard about our office:

- Insurance Company Print ad Dentus promotion Dentus staff member
 Facebook Internet search Dentus website Referral by friend or family

If a friend or family member referred you to our office, we would like to thank them.

Please list their name: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP CODE

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____ Birthdate: ____ / ____ / ____

Spouse's Employer: _____ Work Phone #: _____

Employer's Address: _____

CITY STATE ZIP CODE

Account Info

THE INFORMATION PROVIDED HERE IS FOR THE PERSON FINANCIALLY RESPONSIBLE FOR THIS PATIENT.
THE PERSON NAMED MUST BE THE PERSON WHO SIGNS THIS FORM.

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP CODE

Own Rent How long at this address? _____

If less than one year, how long at previous address? _____

SS#: _____ Work Phone #: _____

Driver's Licence # & State: _____

Payment Method: Payment in Full Ins/Payment plan, on approved credit

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 ALL BALANCES AND MAY OPT FOR A PAYMENT PLAN UPON APPROVED CREDIT.

Signature: _____

THERE WILL BE A CHARGE OF \$58.00 PER HOUR FOR MISSED APPOINTMENTS WITH LESS THAN 24 HOURS NOTICE.

Insurance Info

Primary Dental Insurance

Ins. Co. Name: _____

Address: _____

CITY STATE ZIP CODE

Ins. Co. Phone #: _____

Subscriber SS# / ID#: _____

Group #: _____

Relation: _____ Birthdate: ____ / ____ / ____

Insured's Employer: _____

Secondary Dental Insurance

Ins. Co. Name: _____

Address: _____

CITY STATE ZIP CODE

Ins. Co. Phone #: _____

Subscriber SS# / ID#: _____

Group #: _____

Relation: _____ Birthdate: ____ / ____ / ____

Insured's Employer: _____

In Case of Emergency

Who should we contact?: _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor?: _____

M.D.'s Phone #: _____

FOR OFFICIAL USE ONLY: UPDATES

INITIAL DATE INITIAL DATE INITIAL DATE

