WELCOME TO OUR PRACTICE!

CONFIDENTIAL PATIENT INFORMATION

NAME__________ SEX: ☐ M ☐ F __________
FIRST MI LAST PREFERRED NAME

HOME NO__________ WORK NO__________ EXT______ CELL NO__________

SOCIAL SECURITY #__________ DOB:__________ AGE____ ☐ MINOR ☐ S ☐ M ☐ W ☐ SEP ☐ D

WHICH NUMBER DO YOU WANT US TO USE WHEN WE CONFIRM FUTURE APPTS? ☐ HOME ☐ CELL ☐ WORK ☐ OTHER__________

PHYSICAL ADDRESS__________ APT#______ CITY__________ STATE_____ ZIP______

MAILING ADDRESS (IF DIFFERENT THAN ABOVE)__________

EMPLOYED BY__________ OCCUPATION__________

BUSINESS ADDRESS__________ CITY__________ STATE_____ ZIP______

(IF COLLEGE STUDENT) SCHOOL__________ CITY__________ STATE______

EMERGENCY CONTACT: __________ PHONE NUMBER/S: __________ __________

REFERRED BY__________

RESPONSIBLE PARTY INFORMATION ☐ SAME AS ABOVE

NAME__________ ☐ MALE ☐ FEMALE
FIRST MI LAST

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ OTHER__________

SOCIAL SECURITY #__________ BIRTHDATE__________ DRIVER'S LICENSE #__________

ADDRESS__________ APT#______ CITY__________ STATE_____ ZIP______

HOME #__________ WORK #__________ EXT______ CELL #__________ OTHER__________

EMPLOYED BY__________ EMPLOYER'S ADDRESS__________

PARENT/GUARDIAN CONSENT

I hereby give consent for treatment of my child, __________. I understand the proposed treatment plan may include possible x-rays and the use of local anesthetics, when deemed necessary, for the comfort and well-being of the child. I know that I am responsible for any charges which may occur during his/her dental visit. I understand that the recommendation made to me may change during treatment.

__________ DATE__________
Signature of Parent/Guardian

***Credit Card # To Keep On File (for use when minors come unattended by parents)* MC Visa #__________ DIC#______ Exp: ______

DENTAL INSURANCE INFORMATION (PLEASE PRESENT YOUR INSURANCE CARD TO BE COPIED) ☐ See Attached Card

SUBSCRIBER'S NAME__________ INSURANCE COMPANY__________

RELATION TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER CLAIMS ADDRESS __________

SUBSCRIBER'S EMPLOYER__________ __________

SUBSCRIBER'S SSN__________ GROUP #__________

SUBSCRIBER'S DOB______ ID#__________ NO. TO VERIFY BENEFITS__________

NAME OF OTHER DEPENDENTS COVERED UNDER THIS PLAN

__________ __________ __________ __________
__________ __________ __________ __________

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS AUTHORIZATION

I understand it is the policy of this office to require payment in full for all services rendered to me, or to my dependents, at the time of visit unless other arrangements have been made with the business manager.

I authorize payment directly to Dr. Meredith D. Taylor for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf, or on behalf of my dependents.

I authorize the above doctor and/or provider of services in this office to release any information required to process insurance claims to secure payment of benefits on my behalf, or on behalf of my dependents. I authorize the use of my signature on all insurance claim submissions.

*Signature*__________ *Date* __________