Patient information

Name ____________________________________
Last Name

____
First Name Middle Initial

Preferred Name ________________M____F____
DOB ___/___/___ Age ____ SSN ____________
Home Address ____________________________
City ___________ State _____ Zip Code ______

Contact Information

Home ______________ Cell ________________
Work _______________ Other _______________
E-mail ____________________________________
Employer _________________________________
Occupation ________________________________

Who may we thank for referring you?

Yellow pages Internet Flyer
Family Friend (Name) __________
Other_____________________________________

Spouse / Parent Information

Name _____________________________________
Employer __________________________________
DOB ___/___/___ Age ____ SSN ____________
Work # _____________ Cell # _______________

In Case of Emergency

Name _____________________________________
Relationship _______________________________
Work # _____________ Cell # _______________
Other _____________________________________

Financially Responsible Party

(If other than patient)

Name _____________________________________
Relationship _______________________________
DOB _____/_____/_____ SSN _______________
Work # _____________ Cell # _______________

Primary Dental Insurance

Insured's Name _____________ Relation _______
Insured's DOB ___/___/___ SSN _____________
Insured's Employer _________________________
Insurance Co. ______________________________
Group Plan # ______________________________
Ins. Address _______________________________
Ins. Phone # _______________________________
Ins. ID # __________________________________

Secondary Dental Insurance

Insured's Name _____________ Relation _______
Insured's DOB ___/___/___ SSN _____________
Insured's Employer _________________________
Insurance Co. ______________________________
Group Plan # ______________________________
Ins. Address _______________________________
Ins. Phone # _______________________________

AUTHORIZATION

I certify that I have read or have had read to me the contents of this form. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. The information on this page and the dental/medical histories are correct to the best of my knowledge.
I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as necessary for proper care. I understand that I am responsible for all costs of dental treatment. I hereby authorize my insurance benefits to be paid directly to the dentist. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I understand there will be a 1.5% monthly interest on delinquent accounts (18% APR)
I understand that I am required to provide Comfort Family Dentistry a 48 hour notice upon cancellation of my appointment. Failure to do so could result in a $75.00 charge on my account.

Signature____________________ Date_________