PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

PERSONAL INFORMATION

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Home Phone_____ Wireless Phone_____

Email_____

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] Wireless [ ] Email [ ] Text

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] Wireless [ ] Email [ ] Text

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] Wireless [ ] Email [ ] Text

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Part time

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber Birthday _____

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber Birthday _____

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

The undersigned hereby authorizes Brick Dental Studio and its doctors to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Brick Dental Studio and its doctors to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time of services are rendered unless prior financial arrangements have been made. I hereby authorize Brick Dental Studio to release all information necessary to secure the payment of benefits. I assign directly to Brick Dental Studio all insurance benefits otherwise payable to me. Any payments received by Brick Dental Studio from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic. I understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Signature: _____ Date: _____

Dentist Signature: _____