PLEASE PRINT ***PATIENT INFORMATION*** **Date: _____**

Name: _____ Phone: Hm_____-_____-_____
Last First M.I.
Wk_____-_____-_____
Address: _____ Cell_____-_____-_____
_____
City State Zip Code Gender: M_____F_____
Birth date ____/_____/____ Age____
TX Drivers License#_____ Patient SS#: _____-_____-_____
Employer:_____

Referring Dentist:_____
Spouse_____
Employer: _____Phone#: _____-_____-_____

Parent or Guardian _____ Phone#: _____-_____-_____

Nearest relative not living with you_____Phone# _____-_____-_____

DENTAL INSURANCE INFORMATION

Employee: _____ Employee's SS#: _____-_____-_____
Last First M.I. Birth Date: _____-____-_____

Phone: (hm) ____-_____-_____ (wk) ____-_____-_____

Employer: _____

Insurance Co. _____ Phone#: _____ Group#: _____

*****If you have secondary insurance coverage please let us know!!*****

PLEASE COMPLETE AND SIGN INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr. _____ 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 hereby authorize the

doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. _____
_____ ___/___/___
Responsible Party Signature Relationship Date

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. INITIALS _____.