Welcome

Thank you for choosing us for your dental needs. We promise to do our best to provide you with the finest care. If you have any questions about our office or this form, please do not hesitate to ask.

PATIENT INFORMATION

Patient Name_____ **Date** _____

Address_____ **City** _____

State_____ **Zip**_____ **Home Phone** _____

Work Phone_____ **Cell Phone** _____

Soc Sec #_____ **Birthday** _____

Email_____ **Sex:** ☐ **Male** ☐ **Female**

Please check one: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Student**

Patient's Employer or School _____

Spouse's Name & Employer _____

Who is responsible for this account? _____

Relationship to the Patient _____

Who may we thank for referring you? _____

INSURANCE INFORMATION

Primary Insurance Company _____

If not you, Policy Holder's Name _____

Policy Holder's SSN _____ **Date of Birth** _____

Policy Holder's Employer _____

Relationship to the Patient _____

If Applicable, Secondary Insurance Company _____

Policy Holder's Name_____

SSN _____ **Date of Birth** _____

Relationship to Patient _____

ADDITIONAL:

Reason for todays visit_____

Approximate date of last dental visit _____

Emergency Contact Name & Phone# _____

I certify that the information I have provided here is accurate. If I have insurance, I assign benefits for services to be directly paid to Four Peaks Family Dentistry. I understand that I am financially responsible for any and all charges rendered. I authorize the use of my signature on all insurance submissions and allow the dentist to disclose my health care information for purposes of obtaining payment and/or benefits from the insurance company(ies).

_____ _____

Signature **Date**

Relationship to Patient: _____