1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Child ☐ Other

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

If Child, Parent's Name _____

If Child, Parent's Birthdate _____

Spouse's Name _____

Birthdate of Spouse _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you _____

Reason for leaving previous dentist _____

_____

2 DENTAL INSURANCE

Who is responsible for this account _____

_____

Relationship to Patient _____

Insurance Company _____

Group # _____

Social Security # of Insured _____

Subscriber's Name _____

Birthdate _____ SS# _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Scottsdale Dental Clinic P.C. 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 the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that Scottsdale Dental Clinic P.C. will only bill one primary insurance company. I am responsible for billing secondary insurance if applicable.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home _____ Work _____ Ext _____ Spouse's Work _____

Best time and place to reach you _____

IN CASE OF AN EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____