Patient Information Form

PATIENT INFORMATION

DATE _____

NAME_____ □ MARRIED □ SINGLE □ MINOR □ MALE □ FEMALE
LAST FIRST MI

ADDRESS_____
STREET APT# CITY STATE ZIP

BIRTHDATE_____ TELEPHONE_____
MONTH DAY YEAR HOME# WORK# CELL# E-MAIL

PLACE OF EMPLOYMENT_____ SS#_____

IF FULL TIME STUDENT, SCHOOL NAME_____ GRADE_____

PERSON RESPONSIBLE FOR ACCOUNT:

PLEASE CHECK ONE ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION

MINOR CHILD MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION ADULTS COMPLETE PRIMARY INSURED DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED/ IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY	**SECONDARY INSURED**
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME# WORK# CELL#	HOME# WORK# CELL#
BIRTHDATE: E-MAIL	BIRTHDATE: E-MAIL
EMPLOYER DENTAL INS CO	EMPLOYER DENTAL INS. CO
SS# SUBSCRIBER# GROUP#	SS# SUBSCRIBER# GROUP#

PERSON TO CONTACT IN CASE OFEMERGENCY

Outside of Immediate Family/Household
Name_____
Address_____
City/State/Zip_____
Telephone #_____
Relationship_____

Who may we thank for referring you to our office? Or How did you hear about our practice?

_____

METHOD OF PAYMENT

Responsible party currently has an account in this office
□ Yes □ No
□ Payment in full at each appointment (cash or personal check)
□ Payment in full at each appointment (□ VISA □ MC □ OTHER)
Card # Exp. Date

SERVICE CHARGE
In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to the effect collection of this account or future outstanding accounts

I authorize the use of this signature on all my insurance submissions whether manual or electronic

AUTHORIZATION

I hereby authorize payment directly to Aurora dental Care from the group Insurance benefits otherwise payable to me I understand that I am responsible for all costs of dental treatment. I hereby authorize Aurora Dental Care to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals

Signed: _____
Patient or Responsible Party

Date: _____