PATIENT INFORMATION

Name _____ Birth Date_____

SS# _____(Check One) ____Single ____ Married ____ Divorced_____ Widow/Widower

Address _____ City_____ State _____Zip Code _____

Phone# _____Cell#_____ E-mail _____

How did you hear about our office?_____

Person responsible for account:

Name_____ SS# _____

Birth Date _____ Relationship to Patient_____ Address_____

City_____ State_____ Zip Code_____

DENTAL COVERAGE

Employee_____ Birth Date_____ SS# _____

Employer_____ Employee Address_____

Relationship of Patient to Employee: (Check One) _____ Self _____Child _____ Spouse _____Other

Additional Dental Coverage?_____Yes ____No If yes, please complete this section also.

Employee _____Birth Date _____SS# _____

Employer _____Employer Address_____

Relationship of Patient to Employee: Check One) _____Self _____ Child _____Spouse _____Other

PLEASE PRESENT ALL DENTAL INSURANCE CARDS SO WE CAN SCAN THEM

SIGNATURE ON FILE

I authorize release of any information relating to each claim. I understand that I am responsible for all costs of dental treatment regardless of insurance benefits. I here by authorize payment directly to GENTLE DENTAL CARE, Dr. Glenn R. Burns, of the insurance benefits otherwise payable to me.

Signature of Covered Person/Employee Date