Patient's Name_____DOB_____
First Last

How did you know about our office? Sign___ Yellow pages__ Insurance Dir.__ Ad.___ Patient/Friend_____

**Dental Insurance – 1st Coverage (if any)**

Employer_____Yrs. at this job_____ Name of Ins. Co. _____

Employee Name_____ Employee date of birth_____ SSN_____

Tel. of Ins. Co_____Program/Policy #_____Union/Group #_____

**Dental Insurance – 2nd Coverage (if any)**

Employer_____Yrs. at this job_____ Name of Ins. Co. _____

Employee Name_____ Employee date of birth_____ SSN_____

Tel. of Ins. Co_____Program/Policy #_____Union/Group #_____

I certify that I have provided ALL insurance information. Federal and state law requires that this office collect from insurance carriers in a specific order.

I certify that I will notify this office of any update of this information

I hereby authorize a request the performance of dental services for the patient.

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes of dental treatment.

I understand that I am responsible for payment of any denial of coverage due to failure to disclose use of benefits at another office.

I understand the PAYMENT IN FULL is due at time of service by credit card, cash or verified insurance coverage.

I understand that a MISSED APPOINTMENT CHARGE will apply for appointments missed with less than one business day notice before appointment

I have had all of my questions answered

Signature of responsible party_____ Date_____

STAFF USE ONLY: Dentist's Medical History review & Significant Findings

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Signature Dr._____ Date_____