Patient Information Form

Patient Name: First _____, **Middle** _____, **Last** _____

DOB: _____; **SS#:** _____; **Sex: M** ____ / **F** _____

Full Address: _____

_____

Alternate Address: _____

_____

Phone: _____ ☐

Cell: _____ ☐

Email: _____ ☐

Please check your preferred way to be contacted

How did you hear about us? _____ **Referred By :** _____

Emergency Contact:

Name: _____; **Phone #:** _____; **Relationship:** _____

Primary Dental Insurance Information

Employer's Name:_____

Insurance Holder's Name (Full): _____

Relationship to Patient: _____

DOB: _____; **SS#:** _____; **Sex: M** ____ / **F** _____

Insurance Company Name: _____

Insurance ID #: _____; **Group #:** _____

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Secondary Dental Insurance Information (if any)

Insurance Holder's Name (Full): _____

Relationship to Patient: _____

DOB: _____; **SS#:** _____; **Sex: M** ____ / **F** _____

Insurance Company Name: _____

Insurance ID #: _____; **Group #:** _____

I authorize the release of any information needed for the processing of any dental claims. I further authorize payment of any outstanding balance on this and future claims to be paid directly to H Dental LLC.

Please print your full name: _____

Sign: _____; Date: _____