

Your dental health and happiness are the primary goals for our team. Please accurately complete this confidential form to help these goals become a reality for you!



Today's Date:\_\_ Name: \_\_

## **About You**

☐ Male ☐ Female I pref	for to be o		Middle Initia
☐ Single ☐ Married ☐			
Birth Date://			
Home Address:			
City		State	Zip
Home Telephone #:			
Work #:	Ext:	_ Cell #:	
Email Address:			
Employer:			
Employer's Address:			
Occupation:		How Lon	ıg Held:
Best Time/Place to Reach:			
Previous/Present Dentist:			
(please circle)			
Date of Last Dental Visit:_			
<b>2</b> Spouse	e Inf	forma	ation
Name:		First	ation  Middle Initia
Name:  Last  Employer:		First	Middle Initia
Name:  Last  Employer:  Work #:		First	Middle Initia
Name:  Last  Employer:		First	Middle Initia
Name:  Last  Employer:  Work #:	SS #	First	Middle Initia
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Name:  Last  Employer:  Work #:  Birth Date:  Referre	SS#	First  :  form y seen in our contact the second con	Middle Initia  Ext.:   ation  office?
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## www.excellenceindentistry.com

<b>Dental Insurance</b>
Insurance Co.:
Insurance Co. Address:
Insurance Co. Phone #:
Group # (Plan, Local or Policy #):
Insured's Name: Relation:
Insured's Birth Date:// ID/SS #:
Insured's Employer:
Secondary
Dental Insurance
Insurance Co.:
Insurance Co. Address:
Insurance Co. Phone #:
Group # (Plan, Local or Policy #):
Insured's Name: Relation:
Insured's Birth Date:// ID/SS #:
Insured's Employer:
Consent
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I consent to the disclosure of my records to the following persons who are

involved in my care or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

Signatura	of Patient	(006	Juandian	١
Signature	or Patient	(or (	<b>∡uardian</b>	