WELCOME TO OUR PRACTICE!

CONFIDENTIAL PATIENT INFORMATION

NAME_____ SEX: ☐ M ☐ F _____
FIRST MI LAST PREFERRED NAME

HOME PHONE_____ WORK PHONE_____ EXT_____

MOBILE PHONE_____ EMAIL_____

SOCIAL SECURITY #_____ DOB:_____ AGE____ ☐ MINOR ☐ S ☐ M ☐ W ☐ SEP ☐ D

WHICH NUMBER DO YOU WANT US TO USE WHEN WE CONFIRM FUTURE APPTS? ☐ HOME ☐ CELL ☐ WORK ☐ OTHER_____

PHYSICAL ADDRESS_____APT#_____CITY_____STATE_____ZIP_____

MAILING ADDRESS (IF DIFFERENT THAN ABOVE)_____

EMPLOYED BY_____OCCUPATION_____

BUSINESS ADDRESS_____CITY_____STATE_____ZIP_____

(IF COLLEGE STUDENT) SCHOOL_____CITY_____STATE_____

EMERGENCY CONTACT: _____ PHONE NUMBER/S: _____

REFERRED BY_____

RESPONSIBLE PARTY INFORMATION ☐ SAME AS ABOVE

NAME_____ ☐ MALE ☐ FEMALE
FIRST MI LAST

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ OTHER_____

SOCIAL SECURITY #_____ BIRTHDATE_____ DRIVER'S LICENSE #_____

ADDRESS_____APT#_____CITY_____STATE_____ZIP_____

HOME #_____ WORK #_____EXT_____ CELL #_____ OTHER_____

EMPLOYED BY_____EMPLOYER'S ADDRESS_____

PARENT/GUARDIAN CONSENT

I hereby give consent for treatment of my child, _____. I understand the proposed treatment plan may include possible x-rays and the use of local anesthetics, when deemed necessary, for the comfort and well-being of the child. I know that I am responsible for any charges which may occur during his/her dental visit. I understand that the recommendation made to me may change during treatment.

_____ DATE_____
Signature of Parent/Guardian

**Credit Card # To Keep On File (for use when minors come unattended by parents) MC Visa #_____ DIC#_____ Exp:_____

DENTAL INSURANCE INFORMATION (PLEASE PRESENT YOUR INSURANCE CARD TO BE COPIED) ☐ See Attached Card

SUBSCRIBER'S NAME_____ INSURANCE COMPANY_____

RELATION TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER CLAIMS ADDRESS _____

SUBSCRIBER'S EMPLOYER_____ _____

SUBSCRIBER'S SSN_____ GROUP #_____

SUBSCRIBER'S DOB_____ ID#_____ NO. TO VERIFY BENEFITS_____

NAME OF OTHER DEPENDENTS COVERED UNDER THIS PLAN

_____ _____ _____ _____

_____ _____ _____ _____

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS AUTHORIZATION

I understand it is the policy of this office to require payment in full for all services rendered to me, or to my dependents, at the time of visit unless other arrangements have been made with the business manager.

I authorize payment directly to Dr. Meredith D. Taylor for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf, or on behalf of my dependents.

I authorize the above doctor and/or provider of services in this office to release any information required to process insurance claims to secure payment of benefits on my behalf, or on behalf of my dependents. I authorize the use of my signature on all insurance claim submissions.

Signature_____ Date _____