Today's date:	Medical Physician:

PATIENT INFORMATION

Patient's First Name / Last:			Marital Status (circle one) Single / Married / Divorced / Separated / Widowed	
Birth Date: / /	Social Security Number:	Age:	Sex: ❑ M ❑ F	Phone Number:
Street Address:		City:		State / ZIP Code:
Employer:	Occupation:			Employer Phone Number:
Person Responsible For Billing (if other than patient)	Address:			Phone Number:

Referred to clinic by (please check one box):

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Insurance Network ❑ Drive-By

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No

Name Of Primary Insurance:

Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Group Number:	Policy Number:

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group Number:	Policy Number:

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

CONSENT

Emergency Contact, local friend or relative (not living at same address):	Relationship to patient:	Phone Number:

I give *10th Street Dental* permission to discuss my dental treatment, scheduling, billing, insurance, etc. with the following people:

_____ _____

Name / Relationship Name / Relationship

I have read a copy of this office's Notice of Privacy Practices and I consent for *10th Street Dental* to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize *10th Street Dental* or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*