Primary Dental Insurance

Insurance Co. Name _____ Group # _____
(Plan, Local, or Policy #)

Insurance Co. Phone # _____

Insurance Co. Address _____

Insured's Name _____ Relationship to Patient _____

Insured's Birthdate ____/____/____ Insured's SS # _____

Insured's Employer _____

Secondary Dental Insurance

Insurance Co. Name _____ Group # _____
(Plan, Local or Policy #)

Insurance Co. Phone # _____

Insurance Co. Address _____

Insured's Name _____ Relationship to Patient _____

Insured's Birthdate ____/____/____ Insured's SS # _____

Insured's Employer _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name _____ Relationship _____

Home # _____ Work # _____ Other # _____

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA.the CDC and the ADA.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____ _____
Signature Date

OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY

Medical History Update

Date _____ Comments _____ Signature _____ Dr. Initials _____

Date _____ Comments _____ Signature _____ Dr. Initials _____

Date _____ Comments _____ Signature _____ Dr. Initials _____