

Welcome to Downtown Dental Care!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

E-mail Address: _____, Last Name: _____ First Name: _____

Preferred to be called: _____, Mailing Address: _____

Home Phone: _____, Work Phone: _____ Cell Phone: _____

City, State, Zip: _____ Date of Birth: _____

SS#: _____, Driver's License: _____ Sex: M F Occupation: _____

Employer: _____, Address, City State, Zip _____

Emergency Contact Name: _____ Phone # : _____

Spouse's/ Partner Name: _____ Occupation: _____

Spouse's/ Partner Address (if different than above): _____, City, State, Zip: _____

Spouse's/ Partner Employer: _____ Address, City, State, Zip: _____

Names of other members of your household: _____

In the event that we must contact you for scheduling changes, etc, please indicate the best **PHONE NUMBER** during business hours to phone you:

Phone number: _____, Place _____ Time: _____

Please let us know how you heard about us: _____

INSURANCE INFORMATION:

Primary Insurance Company : _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____ SS#: _____ Birth date: _____

Group# or Policy # _____

Flexible Spending accounts: All balances are to be paid in full at time of service, you will then receive an itemized receipt for services rendered for your flexible account reimbursement directly to you.

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Downtown Dental Care of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: _____ Patient's Signature: _____