Patient Information

Patient Name: ______________________ Preferred Name: ______________________

Address: ______________________ City: ____________ State: ______ Zip: ________

Cell Phone: ______________________ Home Phone: ______________________

Email: ______________________ ☐ Married ☐ Single ☐ Child

Gender: ________ Age: ______ Date of Birth: ____________ Social Security #: ____________

Employer: ______________________ Occupation: ______________________

Work Address: ______________________ Work Phone: ______________________

Emergency Contact: ______________________ Phone: ______________________

Who may we thank for referring you? ______________________

Parent / Guardian Information (if under the age of 18)

Patient Name: ______________________ Preferred Name: ______________________

Address: ______________________ City: ____________ State: ______ Zip: ________

Cell Phone: ______________________ Home Phone: ______________________

Gender: ________ Age: ______ Date of Birth: ____________ Social Security #: ____________

Employer: ______________________ Occupation: ______________________

Work Address: ______________________ Work Phone: ______________________

Insurance Information

Primary Insured (Subscriber): ______________________ Relationship to Patient: ______________________

Date of Birth: ______________________ Subscriber ID#: ______________________

Subscriber Employer or Plan Sponsor: ______________________ Group #: ____________

Insurance Company: ______________________

Additional Insurance

Primary Insured (Subscriber): ______________________ Relationship to Patient: ______________________

Date of Birth: ______________________ Subscriber ID#: ______________________

Subscriber Employer or Plan Sponsor: ______________________ Group #: ____________

Insurance Company: ______________________

Authorization and Release

I authorize my insurance company to pay Dynamic Dental Care all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. Dynamic Dental Care may use my health information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to the HIPAA guidelines.

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PATIENT / PARENT or GUARDIAN SIGNATURE PRINTED NAME DATE