PATIENT INFORMATION

Name _____ Birth Date _____

SS# _____ (Check One) _____Single _____Married _____Divorced _____Widow/Widower

Address _____ City_____ State _____ Zip Code _____

Phone# _____ Cell# _____ E-mail: _____

How did you hear about our office? _____

Person responsible for account:

Name _____ SS# _____ Birth Date _____

Relationship to Patient _____

Address _____ City _____ State_____ Zip Code_____

DENTAL COVERAGE

Employee_____ Birth Date_____ SS# _____

Employer_____

Employee Address_____

Relationship of Patient to Employee: (Check One) _____ Self _____Child _____ Spouse _____Other

Additional Dental Coverage? ___Yes ____No If yes, please complete this section also.

Employee _____ Birth Date _____SS# _____

Employer _____

Employer Address_____

Relationship of Patient to Employee: Check One) _____Self _____ Child _____Spouse _____Other

PLEASE PRESENT ALL DENTAL INSURANCE CARDS SO WE CAN SCAN THEM

SIGNATURE ON FILE

I authorize release of any information relating to each claim. I understand that I am responsible for all costs of dental
treatment regardless of insurance benefits. I hereby authorize payment directly to GENTLE DENTAL CARE, Jennifer Lape DDS of the insurance benefits otherwise payable to me.

_____

Patient/Parent Signature Date