CONFIDENTIAL PATIENT INFORMATION

(Please Print Clearly)

Patient Information

Name:_____ Birth Date:___/___/___ □ Male □ Female
Address:_____ City & State:_____ Zip Code:_____
Cell Phone:(___)_____ Home Phone:(___)_____ Work Phone:(___)_____
E-mail:_____ Driver's License #:_____
Social Security #:_____ Employer's Name:_____

Responsible Party (Primary Insurance Information)

Name:_____ Relationship to Patient:_____
Social Security #:_____ Driver's License #:_____ Birth Date:_____
Employer's Name:_____ Phone Number:(___)_____
Address:_____ City & State:_____ Zip Code:_____
Name of Insurance Company:_____ Phone Number:(___)_____
Union/Local:_____ Group Number:_____
Occupation:_____ Date of Hire:_____

Second Insurance Information (Complete this section if patient is covered by another insurance company)

Name of Insured:_____ Relationship to Patient:_____
Social Security #:_____ Driver's License #:_____ Birth Date:_____
Employer's Name:_____ Phone Number:(___)_____
Address:_____ City & State:_____ Zip Code:_____
Name of Insurance Company:_____ Phone Number:(___)_____
Union/Local:_____ Group Number:_____
Occupation:_____ Date of Hire:_____

Getting to know You and Your Family

How did you hear about Golden Triangle Dental?_____
When was last dental visit?_____ Last dental x-rays taken?_____ What treatment was performed?_____

Please list all immediate family members:

Name	Relationship	Birth Date	Date of last dental visit

Emergency Contact (Friend or relative not living with you)

Name:_____ Phone Number(___)_____ Cell Phone:(___)_____

So we may bill your insurance directly, please sign.

I hereby authorize payment direct to the treating office of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance. I authorize dental care and the release of any information necessary to bill my insurance carrier. In the event of default, I understand that I will be charged and I agree to pay all reasonable collection charges and/or attorney fees.

_____ _____
Signature of the Insured/Responsible Party Date

FOR SIX MONTH RECALL ONLY

I hereby confirm there have been no changes to the above information.

_____ _____
Signature of the responsible party Date