

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.



Patient Information

Name _____
Last First Middle Initial
Address _____ City, State, Zip Code _____
Birth date _____ Social Security No _____ Sex: M F Single Married Separated Divorced Widowed
Home Phone _____ Work Phone _____ Cell Phone _____
Email _____ Relationship to Responsible Party _____ How did you hear about us? _____

Emergency Information

Person to contact in an emergency _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____

Responsible Party / Insurance Information

Name _____
Last First Middle Initial
Address _____ City, State, Zip Code _____
Birth date _____ Social Security No _____ Sex: M F Single Married Separated Divorced Widowed
Home Phone _____ Work Phone _____ Cell Phone _____
Email _____ Relationship to Patient _____

Employer _____

Spouse's Name _____
Last First Middle Initial

Spouse's Employer _____

PRIMARY DENTAL INSURANCE

Policyholder's Name _____ Relationship to patient _____

Social Security Number _____ Birth date _____

Insurance Company _____ Group Number _____

Insurance Company Address _____

Name(s) of dependents covered by this plan _____

SECONDARY DENTAL INSURANCE

Policyholder's Name _____ Relationship to patient _____

Social Security Number _____ Birth date _____

Insurance Company _____ Group Number _____

Insurance Company Address _____

Name(s) of dependents covered by this plan _____

Authorization

I hereby authorize payment directly to Heritage Dental Care, Ltd. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all the costs of dental treatment. I understand a SERVICE CHARGE of 1.5% per month (18% annually) may be added on any unpaid balance over 60 days. I hereby authorize Heritage Dental Care, Ltd. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Heritage Dental Care, Ltd. to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____ Patient Parent Guardian Other Date _____
Signature