



# Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Date \_\_\_\_\_

## Patient Information (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Name I prefer to be called \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ OK to Call? Y  N

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Person to Contact in Case of Emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

List Interests/Hobbies \_\_\_\_\_

In the future, would you consider writing a review for our office? \_\_\_\_\_ Do you have a Yelp account? \_\_\_\_\_

## Responsible Party

Name of Person Responsible for Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Insurance Company Phone # \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Insurance Company Phone # \_\_\_\_\_

## Authorization and Release

I authorize Town Square Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Town Square Dentistry insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for all services rendered on my behalf or my dependents.

X \_\_\_\_\_  
Signature of patient (or parent if minor)