Patient Information Form

WE'D LOVE TO KNOW: HOW DID YOU HEAR ABOUT US? _____

PATIENT

Name _____ Social Security# _____
Last First

Address _____ Apt# _____ City _____ Zip _____

Home Phone (_____) _____ Cell (_____) _____

Email _____ Age _____ Birthdate _____

RESPONSIBLE PARTY (If same as above, skip) **Relationship to Patient** _____

Name _____ Social Security# _____
Last First

Address _____ Apt# _____ City _____ Zip _____

Phone (_____) _____ Age _____ Birthdate _____

EMPLOYMENT

Work Phone (_____) _____ Ext _____

Occupation _____ Employer _____

Business address _____ City _____ Zip _____

EMERGENCY CONTACT PERSON

Name _____ Phone (_____) _____
Last First

Physician _____ Phone (_____) _____

INSURANCE / DENTAL PLAN (PRIMARY)

Plan Name _____ Plan Phone # (_____) _____

Employer / Union _____ Group # _____ Plan # _____

Insured's Name _____ Insured's SSN _____ Birthdate _____

(SECONDARY)

Plan Name _____ Plan Phone # (_____) _____

Employer / Union _____ Group # _____ Plan # _____

Insured's Name _____ Insured's SSN _____ Birthdate _____

All unpaid insurance claims are the responsibility of the patient or guardian.

I understand and agree that (regardless of my insurance), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all information on the Privacy Practice and Disclosure Act and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I hereby give my consent to Monfredi Family Dental, LLC, to send mailings, send email reminders and messages, place phone calls or text messages to my addresses and/or phone numbers provided regarding upcoming appointments, insurance items, or any communication pertaining to my clinical care. You may also leave messages at my home, work, or cellular phone.

_____

Signature of Responsible Party or Patient Date