PATIENT INFORMATION

Patient:_____ Birthdate:_____/____/_____
Last First Middle Mo Day Year

Sex: ( )M ( )F Status: ( )Single ( )Married ( )Divorced ( )Widowed SSN: _____-____-_____

Address:_____
Street City / State / Zip

Home Phone:(____)_____ Cell Phone:(____)_____ Work Phone:(____)_____

Email:_____Occupation:_____

Check box if contact information is same for entire family. ☐

Preferred contact method: ( ) Cell Phone ( ) Home Phone ( ) Work Phone ( ) Email

EMAIL & TEXT appointment reminders are automatically ON unless you notify us to deactivate this reminder feature.

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT/ RESPONSIBLE PARTY:

Name:_____Relationship:_____ Phone:(____)_____

DENTAL INSURANCE/ PAYOR INFORMATION:

Relationship to subscriber/ payor: ( ) Self ( ) Spouse ( ) Child

Subscriber/ Payor Name:_____Subscriber Birthdate: ___/___/_____
Last First Middle Mo Day Year

Insurance Company (1):_____ Employer:_____

Policy/ ID#:_____ Group#:_____

Insurance Company (2):_____ Employer:_____

Policy/ ID#:_____ Group#:_____

HAVE YOU USED THE ABOVE INSURANCE(S) AT ANOTHER OFFICE THIS YEAR? ***YES*** ***NO***

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST.

AUTHORIZATION AND RELEASE:

I authorize Obery Dental to release any information including diagnosis and records of any treatments or examinations 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 insurance benefits directly to Obery Dental. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____/_____/_____
Signature of Patient, Parent or Guardian **Date**