Patient Information

Patient's Name: (L) ____________________________ (F) _______________________ (MI) ____________

Preferred Name: ___________________________ DOB: __________________ SSN: ________________

Address: _______________________________________ CITY: _______________ Zip: _______________

Home# _______________________ Work#________________________ Cell# _______________________

Email Address: ____

Please circle if you would like to receive our confirmation by **Text or Email**.

How did you find our practice: ____

Complete the following section if you have insurance:

Responsible parties' relationship to Patient: ____

Name of the Insured: **(L)** _______________________________________ **(F)** __________________________

Insured DOB: _________________________________ SSN/ID#: ___________________________________

Insurance Company Name / PH#: ____

--DO YOU HAVE ANY ADDITIONAL INSURANCE? IF **YES**, COMPLETE THE FOLLOWING—

Responsible parties' relationship to Patient: ____

Name of the Insured: **(L)** ________________________________ **(F)** _________________________________

Insured DOB: ________________________________ SSN#/ID#: ___________________________________

Insurance Company Name/PH#: ____

I hereby grant authority to Family Dental care of Bellevue and/or staff in charge of the patient whose name appears on this form to administer any treatment which may be deemed necessary or advisable in the treatment of this patient. I hereby authorize payment of any insurance benefit, that otherwise would go to me, go directly to Family Dental Care of Bellevue. I understand that I am responsible for payment of dental services provided in this office for myself/dependents. I understand all outstanding balances over 90 days shall accrue interest at a rate of 1.5% per month.

Signature: ____ Date:_________________