PATIENT INFORMATION

ADULT

Name: _____
Last First MI

Preferred Name: _____

Date of Birth: _____ Social Security#: _____

Mailing Address: _____

Street Address: _____ **Email address**: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Work#: _____ Cell#: _____

Is it O.K. to call you at Work? ____Yes ____No Is it O.K. to call you on your Cell? ____Yes ____No

Employer: _____

Position: _____ How Long: _____

Name of Spouse: _____

Birthdate: _____ Social Security#: _____

Employer: _____

Position: _____ How Long: _____

How did you hear about our office? (please be as specific as possible)

_____

Dental Insurance Information

Insurance Company: _____

Insurance ID# _____ Group# _____

Name of Insured: _____ Relationship to Patient: _____

Employer Name: _____

INSURANCE AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED.
I authorize Clarion Dental Care LLC to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and /or other health practitioner.

Signature: _____ Date: _____