

Date: _____

Chart # _____
For office use only

Patient Information

Patient Name _____
Last First MI Preferred name
(Please circle): Gender: F M Marital Status: Single Married Other Child
Social Security #: _____ Birth Date: _____
Phone number: (Home) _____ (Work) _____ (Ext.) _____ (Cell) _____
Home address: _____
Street Apartment #
City State Zip
Email address: _____ Dr. Lic. # _____ State _____
Employer: _____ Occupation: _____ Phone # _____
Address: _____

Spouse or Responsible Party Information

The following information is for the: _____ patient's spouse or responsible party _____ parent or legal guardian
Name: _____ Birth Date: _____
Last First
Phone (Home) _____ (Work) _____ (Cell) _____
Address: _____ City _____ State _____ Zip _____
Email address: _____ Employer: _____ SS# _____
Employer phone# _____ Address: _____
Name of person or office referring you to our practice: _____

Primary Insurance Information

Name of Insured: _____ Is insured a patient? Yes _____ No _____
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip
Insured's Employer: _____ Patient's relation to Insured: _____
Self, Spouse, Child, Other
Insurance Plan Name and Address: _____

For patients with insurance coverage:

- Patients who carry dental insurance understand that all dental services are charged directly to the patient and are responsible for payment of all dental services. As a service, this office will help in the preparation of the dental insurance forms or assist in making collections from the insurance company. When applicable, insurance payments will be assigned to this office and will be credited to the patient's account. I understand this office cannot render services on the assumption that fees will be paid by my insurance company and I will be responsible for any fees not covered by my insurance company.
- I agree to inform this office of any and all changes regarding by dental insurance coverage prior to accepting dental services.

To release information to your insurance company and assign insurance benefits to this office, please read and sign the following:

- I shall review the treatment pertaining to my treatment. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to claims filed by this office.

Signature of patient, parent, or guardian

- As the employee or subscriber of this dental insurance, I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Doerfler or his assignee.

Signature of employee or subscriber

Date: _____