PATIENT INFORMATION

Chart# _____
FOR OFFICE USE ONLY

Patient Name*: _____ (Last) _____ (First) _____ (Mi) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/Dr/etc) Gender*: ◯ Male ◯ Female Family Status*: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date*: _____ Drivers License #: _____ Email Address: _____

Phone: _____ (Mobile) _____ (Work) _____ (Ext.) _____ (Home) Social Security #: _____

How do you prefer to receive your appointment confirmations? ◯ Text ◯ Email ◯ Phone

Address*: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

How did you hear about us?: ◯ Doctor referral ◯ Friend/Family ◯ Found on Google ◯ Found on Healthgrades/Yelp/Other

Name of person, office, or other source referring you to our practice: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for*: ◯ The patient's spouse ◯ The person responsible for payment ◯ Neither-not applicable

Patient Name*: _____ (Last) _____ (First) _____ (Mi) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/Dr/etc) Gender*: ◯ Male ◯ Female Family Status*: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date*: _____ Prov Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext.) _____ (Mobile) Best time to call: _____

Address*: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

EMPLOYMENT INFORMATION

The following relates to: ◯ The patient ◯ The person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

DALLAS DENTAL GROUP
COMPREHENSIVE RESTORATIVE, COSMETIC, AND FAMILY DENTISTRY

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ (Last) _____ (First) _____ (Mi)

Insured Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured: _____ (Last) _____ (First) _____ (Mi)

Insured Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Consent for Services

* ◯ I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

* ◯ I understand that all charges are due at time of service. If I have dental insurance, I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature: _____