barkley village family dentistry

Patient Information

Patient Info

Patient's name ______________________________
LAST FIRST INITIAL

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ MINOR

Address ______________________________

Billing address (if different than above) ______________________________

Phone ______________ ☐ HOME ☐ CELL ☐ BUS.
______________ ☐ HOME ☐ CELL ☐ BUS.

Email ______________________________

SS # ______________________________

Birthdate __/__/__ Age ____ Gender ☐ MALE ☐ FEMALE

Are you a full time college student? ☐ YES ☐ NO

School ______________________________

Parent/Guardian Info (if patient is child or student)

Parent's name ______________________________
LAST FIRST INITIAL

Address ______________________________

Phone ______________ ☐ HOME ☐ CELL ☐ BUS.
______________ ☐ HOME ☐ CELL ☐ BUS.

Patient/Parent Employment Info

Employer ______________________________

Address ______________________________

Position ______________ How long held ____

Spouse name ______________________________

Spouse employer ______________________________

Position ______________ How long held ____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provide to another dentist.

I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I attest to the accuracy of the information on this page.

Account Info

Who is responsible for this account other than insurance?

Name ______________________________

Address ______________________________

Other family members at this practice ______________________________

Whom may we thank for this referral? ______________________________

Dental Insurance 1st Coverage

Subscriber name ______________________________

Subscriber DOB ______________________________

Employer ______________ # of years ____

Name of Insurance Co. ______________________________

Billing Address ______________________________

Union Local or Group # ______________________________

SS# / ID ______________________________

Dental Insurance 2nd Coverage

Subscriber name ______________________________

Subscriber DOB ______________________________

Employer ______________ # of years ____

Name of Insurance Co. ______________________________

Billing Address ______________________________

Union Local or Group # ______________________________

SS# / ID ______________________________

Emergency Contacts (list two people not living with you)

Name ______________ Phone ______________

Name ______________ Phone ______________

____
Patient's or parent's signature

____
Date