



PATIENT INTAKE FORM

Date: Appointment Date: Appointment Time:

PATIENT INFORMATION

Last Name: * First Name: * MI:

Date of Birth: * Age: Gender: * Male Female Other

Social Security Number:

Home Address: *

City: * State: * ZIP Code: *

Home Phone: Cell Phone: * Work Phone:

Email Address: *

Preferred Contact Method: * Home Phone Cell Phone Work Phone Email Text

Emergency Contact Name: * Relationship:

Emergency Contact Phone: *

Employment Status: Employed Self-Employed Retired Student Unemployed

Employer Name:

Employer Address:

Employer Phone:

PRIMARY INSURANCE INFORMATION

Is the patient the primary insurance subscriber? * Yes No

Insurance Company Name: *

Insurance Company Phone: *

Policy/Member ID Number: * Group Number:

Plan Type: PPO HMO DHMO Indemnity Medicare Medicaid

If Patient is NOT the Primary Subscriber:

Subscriber's Last Name: First Name: MI:

Subscriber's Date of Birth: Gender: Male Female

Subscriber's Social Security Number:

Relationship to Patient: Spouse Parent Guardian

Subscriber's Address (if different from patient):

City: State: ZIP Code:

Subscriber's Employer:

SECONDARY INSURANCE INFORMATION (If Applicable)

Does the patient have secondary insurance? Yes No

Insurance Company Name:

Insurance Company Phone:

Policy/Member ID Number: Group Number:

Plan Type: PPO HMO DHMO Indemnity Medicare Medicaid

PATIENT ACKNOWLEDGMENT AND CONSENT

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform the dental office of any changes to my personal or insurance information. I authorize the dental office to verify my insurance benefits and to submit claims on my behalf. I also authorize my insurance company to pay benefits directly to the dental office.

I understand that I am financially responsible for all charges, whether or not they are covered by insurance. I agree to pay any deductibles, co-payments, or non-covered services at the time of service or as agreed upon with the dental office.

Patient Signature (or Parent/Guardian if minor): *

Date: *

Print Name: