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 Patient Information Form

**Thank you for allowing us to take care of all your dental needs and giving you the best care possible by completing the**

**entire form in ink and legibly. If you have questions or need help, just ask. We look forward to being your dentist of choice!**

 First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI: \_\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Jr/Sr: \_\_\_\_

Address: Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Sex (circle) **M F**

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact you by Email? **Y/N**

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is anyone in your family a patient at Irmo Dentistry, if so, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Irmo Dentistry?

 Drive by Internet T.V. Facebook 

 Flyer(Received from)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other(Please Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head of Household and/or Responsible Party for Payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| Do you have Dental Insurance? (circle) **Yes No**Please complete all fields | Do you have Secondary Dental Insurance? (circle) **Yes No** |
| --- | --- |
| **Primary Insured, The Subscriber** | **Secondary Insured** |
| Primary Insurance |  | Secondary Insurance |  |
| Subscriber Name |  | Subscriber Name |  |
| Subscriber ID # |  | Subscriber ID # |  |
| Subscriber Date of Birth |  | Subscriber Date of Birth |  |
| Relationship to Subscriber |  | Relationship to Subscriber |  |
| Employer Name |  | Employer Name |  |
| Employer Phone |  | Employer Phone |  |
| Insurance Group # |  | Insurance Group # |  |
| Insurance Phone # |  | Insurance Phone # |  |
| **\*Please present Insurance card to receptionist to be copied\*** |

 Assignment of Benefits

I authorize payment directly to Irmo Dentistry for all Insurance benefits otherwise payable to me for services rendered. I understand that

I am financially responsible for all charges not paid by insurance, and for all services rendered on my behalf or my dependents. I

authorize Irmo Dentistry to release the information required to secure the payment of benefits. I authorize the use of this signature on all

insurance submissions.

Signature of Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_