Benchmark Family Dentistry

PATIENT INFORMATION

Today's Date_______________

Name____Birthdate_____________SS#___________________

Preferred Name____Home Phone_______________

Address____
City State Zip

Cell Phone___________________Email____________________________Minor____Single____Married____

Patient's or Parent's employer____Work/Cell#_______________

Spouse or Parent's Name______________________Employer_______________Work/Cell#_______________

Person to Contact in Case of Emergency_________________________________Phone___________________

Referred By____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured____Relation to Patient_______________

Address____
City State Zip

Birthdate______________________Social Security #________________Home/Cell Phone________________

Employer of Policy Holder_____________________________________ Work Phone____________________

Insurance Company__________________________Patient ID #______________ Group #__________________

Address____
City State Zip

SECONDARY DENTAL INSURANCE INFORMATION

Named of Insured____Relation to Patient_______________

Address____
City State Zip

Birthdate______________________Social Security #________________ Home/Cell#__________________

Employer of Policy Holder______________________________________Work Phone____________________

Insurance Company__________________________Patient ID #______________ Group #__________________

Address____
City State Zip

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize this signature on all insurance submissions.

Signature of patient or parent if minor____Date____________________