SELECT CARE
DENTAL

PATIENT INFORMATION

NAME OF PATIENT _____
First Middle Last Birthday Age

Preferred Name_____

Resident Address_____
Street No. City State Zip

Mailing Address_____
Street No. City State Zip

Cell Phone No. _(____)_____ ☐ Home Phone No. _(____)_____ ☐
Please check your best contact phone #

Email Address_____

RESPONSIBLE PARTY

Self/Parent_____

Social Security No._____

Driver's License No._____

Cell Phone No. _(____)_____

Is there a dental insurance company that you would like us to bill? Primary ☐ Secondary ☐

Whom may we thank for referring you to our office?

_____

IN CASE OF EMERGENCY CONTACT:_____
Name **Relationship** **Phone #**

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and / or health practitioners. I give my permission for Select Care Dental to leave messages on my homeand/or cell voicemail or with my spouse/partner/caregiver regarding treatment, billing and appointment information. I authorize and request myinsurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment or co-payment is due on the day of service.

_____ _____
Print Name *Date*

_____ _____
Signature of Patient (Or Parent If Minor) *Date*