# PATIENT INFORMATION

***CONFIDENTIAL***

**NAME:** _____ Birthdate: _____
First Middle Last

Address: _____
Street City State Zip

Home Tel.: (  ) _____ Work Tel.: (  ) _____

Cell: (  ) _____ Email: _____

Patient's or Parent's Employer: _____ Occupation: _____

Business Address: _____
Street City State Zip

Spouse or Parent's Name: _____ Employer: _____ Work Phone: (  ) _____

Pharmacy Name: _____ Address: _____

Name of General Dentist who referred you: _____

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____ Home Tel.: (  ) _____ Work Tel.: (  ) _____

## PRIMARY DENTAL INSURANCE INFORMATION

Name of insured (if not patient): _____ Relationship: _____

Birthdate: _____ Subscriber ID: _____

Employer: _____ Work Tel.: (  ) _____

Insurance Company: _____ Group #: _____

Address of Insurance Company: _____
Street City State Zip

**Do you have any secondary dental insurance? □ Yes □ No If yes, complete the following**

Name of insured: _____ Relationship: _____ Birthdate: _____

Subscriber ID: _____ Employer: _____

Group #: _____ Insurance Company: _____

### Authorization, Release, & Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health practitioners. I understand that I may revoke or restrict the foregoing authorization by written instruction addressed to Western Mass Endo Pc.

I authorize and hereby request my insurance company to pay directly to the dentist (or the 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 on behalf of my dependents.

*Signature of patient or parent if minor:* _____ *Date:* _____

*Continued on Back*