

TODAY'S DATE	CHART #				SOCIAL SECURITY #	MARITAL STATUS
MR. MS. MRS. MISS	LEGAL NAME (LAST)	FIRST	MIDDLE	DATE OF BIRTH	SEX MALE FEMALE	EMAIL ADDRESS
ADDRESS		CITY		STATE	ZIP CODE	HOME # ()
EMPLOYER	ADDRESS		WORK # ()		CELL # ()	
RELATIVE (NOT AT SAME ADDRESS)		RELATIVE ADDRESS			PHONE # ()	

ENTER THE NAME AND PHONE NUMBER OF YOUR MEDICAL AND DENTAL PROVIDER(S) WHOM WE MAY THANK FOR YOUR REFERRAL TO COFS. CHECK ALL THAT MAY APPLY.

	NAME	PHONE #		NAME	PHONE#
<input type="checkbox"/>	GENERAL DENTIST	_____	<input type="checkbox"/>	MEDICAL DOCTOR	_____
<input type="checkbox"/>	ENDODONTIST	_____	<input type="checkbox"/>	FAMILY/FRIEND	_____
<input type="checkbox"/>	ORTHODONTIST	_____	<input type="checkbox"/>	SELF	_____
<input type="checkbox"/>	PROSTHODONTIST	_____	<input type="checkbox"/>	OTHER, PLEASE EXPLAIN	_____

HAVE YOU OR A FAMILY MEMBER EVER BEEN A PATIENT OF OUR PRACTICE? NO YES NAME: _____

INSURANCE INFORMATION

MEDICAL/MEDICARE COVERAGE

INSURANCE COMPANY NAME	ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER NAME	SUBSCRIBER BIRTHDATE	SUBSCRIBER SOCIAL SECURITY NO.		
SUBSCRIBER ADDRESS		CITY	STATE	ZIP CODE
EMPLOYER NAME	GROUP NUMBER	POLICY NO.	PATIENT'S RELATIONSHIP TO SUBSCRIBER	
DO YOU HAVE SECONDARY INSURANCE? IF SO, WHAT? <input type="checkbox"/> YES <input type="checkbox"/> NO				

DENTAL COVERAGE

INSURANCE COMPANY NAME	ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER NAME	SUBSCRIBER BIRTHDATE	SUBSCRIBER SOCIAL SECURITY NO.		
SUBSCRIBER ADDRESS		CITY	STATE	ZIP CODE
EMPLOYER NAME	GROUP NUMBER	POLICY NO.	PATIENT'S RELATIONSHIP TO SUBSCRIBER	
DO YOU HAVE SECONDARY INSURANCE? IF SO, WHAT? <input type="checkbox"/> YES <input type="checkbox"/> NO				

FINANCIAL RESPONSIBILITY

PLEASE COMPLETE THE FOLLOWING INFORMATION IF PATIENT IS UNDER 18 OR IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR BILL

RESPONSIBLE PARTY NAME	DOB:	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	HOME PHONE # ()
ADDRESS	CITY	STATE	ZIP CODE	CELL # ()
EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE
			PHONE #	

Final Authorization and Acknowledgement

The following authorization and acknowledgement must be signed by the patient if over eighteen (18) years of age. It must be signed by the responsible person if the patient is a minor. **Likewise, it must be signed by a legal guardian or other responsible person if the patient is over eighteen (18) years of age and not responsible for his/her own debts.**

This authorization and acknowledgement must be signed prior to treatment being rendered.

- (1) I hereby authorize the release of any information relating to my insurance claims.
- (2) I hereby authorize payment to the doctor of benefits otherwise payable to me, but not to exceed the charges shown.
- (3) I agree to pay for the services rendered and acknowledge that I am legally liable for the services.
- (4) I understand that insurance is being filed as a courtesy for me and that I am responsible for the full bill sixty days from the date insurance is filed.
- (5) I agree to pay all collection agency fees/attorney fees and any filing fees, court costs or other expenses incurred if my account is referred to a collection agency or attorney for collections.

DATED: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATED: _____

SIGNATURE OF INSURED IF OTHER THAN PATIENT

