PATIENT INFORMATION FORM

Thank you for choosing our office to assist you with your dental needs. ***Please fill out the information below and don't forget to provide your signature at the end.***

Patient's Name: ________________________ Date of Birth: __________

Sex: ☐ Male ☐ Female Age: __________ Marital Status: __________

Social Security Number: __________________

Email address: ______________________________

Telephone: ______________ ______________ ______________
Home Work Cell Phone

Mailing address: ______________________________________

City: __________________ State: ________ Zip: __________

Ethnicity (optional):

African / American * White Asian * Pacific Islander * American Indian / Alaskan Native * Hispanic

Other:

Whom may we thank for referring you to our office? ______________________

Employer: ____________________ (mandatory for insurance purpose)

INSURANCE INFORMATION: or Not covered by dental insurance: __________

Your ID Number: ________________

Patient Relationship to insured: Self ___ Spouse ___ Child ___ Other ____

Insurance Plan Name: ______________________________

Group Number: __________________

Insured's Employer name & Address: ______________________________

Name of insured: ________________ If insured a patient?: __________

Insured SS # and Date of Birth: __________________ Member ID: ____________

Covered by spouse's insurance? Yes No Spouse's Name: ____________________

<u>Secondary insurance coverage:</u>

Insurance Plan Name: ____________________________

(if you are the subscriber, please skip the following questions)

Your ID Number: __________________

Patient Relationship to insured: Self ___ Spouse ___ Child ___ Other ____

Name of insured: ________________________________

Insured SS #: ____________________ & Member ID: ______________________________

Group Number: ________________________________

If minor, name of legal guardian: ____

Home phone ___________________ **Mobile Phone:** ________________________________

FOR MILITARY ONLY:

Military Rank:

Insured's Date of Birth:	Social Security Number:	ID & Group Number:

Financial Agreement: As a condition for treatment at United implant dentistry PC, financial arrangements must be made in advance. Patients are responsible for the cost incurred for dental treatment agreed upon by the patient. Patients who carry dental insurance understand that all dental services performed are charged directly to the patient and that he or she is personally responsible for the payment of their dental care. United Implant Dentistry will help prepare insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However UNITED IMPLANT DENTISTRY cannot render services on the assumption that the charges will be paid by the insurance companies.Insurance and patient portions are estimates provided as a courtesy. In the event that your insurance carrier pays less than the estimate amount, you are fully responsible for the unpaid balance.

I have read the above conditions concerning payment and voluntarily agree the above conditions.

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Patient / Guardian Signature   Relationship to Patient   Date