ENVISION DENTAL

PLEASE PRINT AND COMPLETE

Patient Information Form

Patient Name: _____ Nickname: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone ( ) _____ Work Phone ( ) _____ Cellphone ( ) _____

Patient Social Security Number: _____ Patient Date of Birth: _____ Gender: M F

Marital Status: Single Married Widowed Divorced

Patient Employer: _____ Email Address: _____

Emergency Contact Person and relationship: _____ Relationship to patient: _____

Emergency Contact Person Phone Number" _____

WHO MAY WE THANK FOR REFERRING YOU? _____

Primary Insurance Information: PLEASE PROVIDE BOTH SOCIAL SECURITY NUMBER AND MEMBER I.D.

Dental Insurance: _____ Insurance Phone Number: ( ) _____

Insurance Address (In Full): _____

Policy Holder's First and Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Social Security Number: _____

Policy Holder's Employer: _____ Policy Holder's Relationship to Patient: _____

Policy Holder's I.D. Number: _____ Policy Holder's Group Number: _____

The above information is accurate and complete to the best of my knowledge and is only for us in treatment, billing and processing insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my family members during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand 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 behalf of myself and dependents.

I also understand that Envision Dental will provide me with an **"estimate"** of what my insurance may or not pay. Envision Dental will not be responsible for what your insurance carrier does not pay.

_____

Signature Date