BROCKIE DENTAL

PATIENT INFORMATION

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

Patient's Name _____ Birthdate _____
(Last) (First) (Mi)

Address _____ City _____ ST____ Zip _____

Home Phone _____ Work Phone _____X_____ Cell Phone _____

E-Mail _____ Social Security # _____

Employer _____ City _____ Occupation _____

Name of Parent /Partner/ Spouse / Guardian _____ Birthdate _____

Address if different _____ City _____ ST_____ Zip _____

Home Phone _____ Work Phone _____X_____ Cell Phone _____

Employer _____ City _____ Occupation _____

In case of emergency, whom shall we notify other than spouse?

Name _____ Relationship _____ Phone _____

DENTAL INSURANCE INFORMATION
PRIMARY

EMPLOYEE NAME _____

INS CO NAME _____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP _____

INSURANCE PHONE _____

GROUP / POLICY # _____

EMPLOYEE ID # _____

EMPLOYEE SS # _____

EMPLOYEE BIRTHDATE _____

DENTAL INSURANCE INFORMATION
SECONDARY

EMPLOYEE NAME _____

INS CO NAME _____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP _____

INSURANCE PHONE _____

GROUP / POLICY # _____

EMPLOYEE ID # _____

EMPLOYEE SS # _____

EMPLOYEE BIRTHDATE _____

Patient Acknowledgments:

- I authorize and request my insurance company to pay directly to the dentist 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 consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes or for use in seminars or publications of this dental office.

I have read the above: Signature _____ Date _____
Parent or Guardian if a minor