Patient Information

Date: _____ Patient's Name: _____ Preferred Name: _____
Social Security #: _____ Birthdate: _____ Home Telephone #: _____
Cell Phone: _____ Best number to call: _____ Email: _____
Street Address: _____
City _____ State _____ Zip Code _____
Mailing Address: _____
City _____ State _____ Zip Code _____
Occupation: _____ Employer: _____
Employer Address: _____ Work #: _____ ext#____
Spouse Name: _____ Birthdate: _____ SS#: _____
Spouse's Occupation: _____ Spouse's Employer: _____

In Case of Emergency Please Contact (someone not living with you)

Name: _____ Relationship to you: _____
Address of Emergency Contact Person: _____
Home Phone: _____ Work Phone: _____

How did you find out about our office? (Please circle all that apply)

Harris Teeter Shopping Cart Harris Teeter Wine Tote Bag Lake Norman Savings Internet Search
Lake Norman Womans Magazine Mooresville Weekly Mooresville Chamber of Commerce Sign/Banner
River Talks Talking Points Mailer/Letter Brawley Roadside Billboard www.mooresville-dentist.com
Friend/Family Member (Name) _____ A current patient named: _____

What concerns do you have regarding dental treatment?
(Please circle all that apply)

Fear of treatment Time of treatment Financial concerns
Distance to office Embarrassment Not understanding treatment
Other_____

Insurance Information

Primary Dental Insurance:

Birth dates and SS# are required for insurance processing

Insurance Co.: _____
Subscriber's Name: _____
Subscriber's SS#: _____ Subscriber's relationship to patient: _____
Subscriber's Employer: _____
Subscriber's Contract#: _____ Group #: _____ Birthdate: _____

Secondary Dental Insurance:

Insurance Co: _____
Subscriber's Name: _____
Subscriber's SS#: _____ Subscriber's relationship to patient: _____
Subscriber's Employer: _____
Subscriber's Contract#: _____ Group #: _____ Birthdate: _____

Assignment and Release:

I, the undersigned certify that I, or my dependant, have insurance coverage with _____. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature **Relationship** **Date**