

Arcadia Dental Group

Patient Information

Patient Name: _____
Address _____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
Birthdate: ____/____/____ Gender: F M Age: _____ Patient SS#: _____ - _____ - _____
Home Phone: _____ Cell: _____
Work Phone: _____ Ext: _____ Best Time to Reach You: _____
I prefer to be called: Mr. Mrs. Miss Other Single Married Widowed Separated Divorced
Occupation: _____ Employer: _____
Spouse's Name: _____ Spouse's Occupation: _____

Responsible Party:

Name of Responsible Party: _____ Relationship: _____
Address _____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
Birthdate: ____/____/____ Age: _____ SS#: _____ - _____ - _____
Employer: _____ Work Phone: _____ Ext. _____

In Case of Emergency, Contact:(Specify someone who does not live in your household.)

Name: _____ Relationship: _____
Home Phone: _____ Work: _____

Who may we thank for referring you? _____

Dental Insurance

Who is responsible for this account: _____
Birthdate: ____/____/____ SS#: _____ - _____ - _____ Relationship to Patient: _____
Insurance Co: _____ Group#: _____
Is Patient covered by additional Insurance? Yes No

Assignment and Release

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I 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

Date