PATIENT FORM – ADULT

TODAY'S DATE:_____

NAME:_____ PHONE:_____ BIRTH DATE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

MARITAL STATUS:_____ SOCIAL SECURITY NUMBER _____

EMPLOYER:_____ OCCUPATION:_____

EMPLOYER ADDRESS:_____

WORK PHONE NUMBER:_____LENGTH OF EMPLOYMENT:_____

CELL PHONE:_____EMAIL:_____

SPOUSE NAME:_____ PHONE:_____ BIRTH DATE:_____

SPOUSE EMPLOYER:_____ SOCIAL SECRUITY NUMBER:_____

EMPLOYER ADDRESS:_____

WORK PHONE NUMBER:_____LENGTH OF EMPLOYMENT:_____

CELL PHONE:_____EMAIL:_____

IN CASE OF EMERGENCY

NEAREST RELATIVE NOT LIVING WITH YOU:_____

ADDRESS:_____ PHONE:_____

RELATIONSHIP TO PATIENT:_____

NAME:_____ CITY:_____ STATE:____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

ARE YOU COVERED BY DENTAL INSURANCE? _____ IF YES, COMPLETE REVERSE SIDE.

INSURANCE INFORMATION

WE PROCESS AND SUBMIT INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS. IN ORDER TO GET BENEFITS FROM YOUR INSURANCE COMPANY YOU MUST PROVIDE US WITH COMPLETE INFORMATION ABOUT YOUR INSURANCE INCLUDING GROUP NUMBERS AND CORRECT ADDRESS. IT IS YOUR RESPONSIBILITY TO KNOW YOUR POLICY AND COVERAGE. WE DO NOT CALL EMPLOYERS FOR THIS INFORMATION. PROFESSIONAL SERVICES ARE RENDERED TO THE PATIENT, NOT TO THE INSURANCE COMPANY. THEREFORE YOU ARE FINANCIALLY RESPONSIBLE FOR CHARGES WHETHER OR NOT THEY ARE BAID BY YOUR INSURANCE COMPANY.

PLEASE COMPLETE THE FOLLOWING INFORMATION

PATIENT NAME:_____ RELATIONSHIP TO SUBSCRIBER:_____

PRIMARY INSURANCE

EMPLOYEE/SUBSCRIBER:_____ SOCIAL SECURITY NUMBER:_____

EMPLOYER:_____ GROUP NUMBER:_____

OCCUPATION:_____ BIRTH DATE:_____

PRIMARY INSURANCE COMPANY NAME & ADDRESS:_____

_____

SECONDARY INSURANCE

EMPLOYEE/SUBSCRIBER:_____ SOCIAL SECURITY NUMBER:_____

EMPLOYER:_____ GROUP NUMBER:_____

OCCUPATION:_____ BIRTH DATE:_____

SECONDARY INSURANCE COMPANY NAME & ADDRESS:_____

_____

I CERTIFY THAT I, AND/OR MY DEPENDENTS HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN BENEFITS DIRECTLY TO DR. MICHAEL BAILEY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHTER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE CLAIMS.

_____ DATE:_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN