

Welcome to Atlantic Dentistry

Tell us about yourself! We'll be glad to assist you in filling out this form if necessary.

_____ Date

Name: _____
Last Name First Name MI

Home: (____) _____ Cell (____) _____ Work: (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birth Date: _____ SSN: _____ - _____ - _____

Email Address: _____ Drivers License #: _____

Married? Widowed? Single? Child? Separated? Divorced?

PATIENT

Employer/School: _____ Occupation: _____

Employer Address: _____

In case of emergency who should be notified? _____

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

The Coastland Times The Independent Sprint Yellow Pages The Beach Book

Primary Insurance***If you are unable to provide us with complete information and your insurance card, we will expect payment in full at the completion of your visit: **NO EXCEPTIONS.**

Subscriber's Name: _____
Last Name First Name MI

Relation to Patient: _____ Subscriber's DOB: _____

Subscriber's SSN: _____ - _____ - _____

Address (if different from pt.) _____ Phone #: _____

City: _____ State: _____ Zip: _____

Person Responsible Employed by: _____

Employer's Address: _____ Phone#: _____

Insurance Company: _____

Subscriber #: _____ Group#: _____

Authorization

I certify that I, and/or my dependent(s), have insurance with and assigns directly to Atlantic Dentistry all insurance benefits, if any, 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 use of my signature for all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of patient, parent or guardian

Date

Signature of guarantor of payment/responsible party

Relationship to Patient: