WELCOME!

Patient Information

Confidential

Name _____ **Birthdate** _____
First Middle Initial Last

Address _____ **City** _____ **State** _____

Zip Code _____ **Phone #** _____ **Cell #** _____

SS# _____ **Married** _____ **Single** _____
(**Needed to file insurance**)

Employer _____ **Work #** _____

Name of person responsible for account _____ **Relationship** _____
(patient, parent of minor, guardian, spouse)

Address _____ **City** _____ **State** _____

Birthdate _____ **SS #** _____

Phone # _____ **Work #** _____

Person to contact in case of emergency _____ **Phone #** _____

How did you find out about our office? _____

_____ **The doctors at Pine Peaks Dental reserve the right to inactivate any patient who has not been seen for 18 consecutive months or more. After this time your chart will be inactivated and you will no longer be considered a patient of record.**
Initial

INSURANCE INFORMATION

Name of insured _____ **Relationship to patient** _____

Birthdate _____ **SS#** _____ **Date employed** _____
(**Needed to file insurance**)

Name of employer _____ **Group #** _____

Insurance Company _____ **Policy #** _____

Insurance Address _____ **Insurance Phone #** _____

Do you have a secondary dental insurance? Yes _____ **No** _____

The undersigned, herby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependants. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims or benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or my dependents and that I will be bound by this signature as though the undersigned has personally signed the particular claim. I understand that it is my responsibility to inform the dental office of any changes which affect the above information.

Signature _____ **Date** _____