



FAMILY AND COSMETIC DENTISTRY
DENTISTRY FOR ALL SEASONS OF LIFE

PATIENT INFORMATION (confidential)

Please print

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_
First Middle Initial Last

If patient is a minor: Parent or legal guardian: \_\_\_\_\_
First Middle Initial Last

Social Security #: \_\_\_\_\_ or Copy of Drivers License \_\_\_\_\_

Address \_\_\_\_\_
City State Zip

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

INSURANCE INFORMATION: Primary Insurance

Name of subscriber: \_\_\_\_\_ Date of Birth \_\_\_\_\_
First Middle Initial Last

Name of Carrier: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_
City State Zip

Subscriber ID #: \_\_\_\_\_ Group # \_\_\_\_\_

Family Members covered under this plan \_\_\_\_\_

Secondary Insurance

Name of subscriber: \_\_\_\_\_ Date of Birth \_\_\_\_\_
First Middle Initial Last

Name of Carrier: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_
City State Zip

Subscriber ID #: \_\_\_\_\_ Group # \_\_\_\_\_

Family Members covered under this plan \_\_\_\_\_

Whom may we thank for your referral: \_\_\_\_\_

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to All Seasons Dental all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize All Seasons Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_