# PATIENT INFORMATION

**CHART #** ____________

## PATIENT

Name ____________ Last ____________ First ____________
Address ____________ Apt. # ____________
City ____________ Zip ____________
How long at this address? ____________
Phone ( ) ____________ Cell/Pager ( ) ____________
E-mail ____________
Social Security # ____________ DL# ____________
Age ____________ Birthdate ____________

## RESPONSIBLE PARTY (If same as above, please skip)

Name ____________ Last ____________ First ____________
Address ____________ Apt. # ____________
City ____________ Zip ____________
How long at this address? ____________
Phone ( ) ____________
Social Security # ____________ DL# ____________
Relationship to Patient ____________
Age ____________ Birthdate ____________

## EMPLOYMENT

Occupation ____________
Employer ____________
How Long? ____________
Business Address ____________
City ____________ Zip ____________
Business Phone ( ) ____________ Ext. # ____________
Verified By ____________ (Office use only) Date ____________

## REFERENCES

Name ____________ Last ____________ First ____________
Address ____________ Apt. # ____________
City ____________ Zip ____________
Phone ( ) ____________
Name ____________ Last ____________ First ____________
Address ____________ Apt. # ____________
City ____________ Zip ____________
Phone ( ) ____________
Spouses Name ____________ Last ____________ First ____________
Spouses Work # ( ) ____________

## PERSON TO CONTACT FOR EMERGENCY:

____________
Last First
____________
Address
City ____________ Zip ____________ Tel# ( ) ____________
Physician Name ____________ Tel# ( ) ____________

## GETTING TO KNOW YOU

Are there other members of your household who are not patients at our office?

YES ____ NO ____ Please list names & relationship (son, daughter, husband) below:

1: ____________ 2: ____________
3: ____________ 4: ____________

**How did you hear about our office?**

**TV** ___ **Radio** ___ **Billboard** ___ **ConfiDent©** ___ **Website** ___
**Yellow Pages** ___ **Printed Material** ___ **Insurance Plan** ___
**Walk-in-Sign** ___ **Family or Friend** ___ **Internal Office Transfer** ___

I want information in Spanish: YES ___ NO ___

## INSURANCE

Primary Insurance Company
Name ____________
Address ____________
City, Zip ____________
Insurance Co. Phone # ____________
Employer ____________
Union/Local ____________ Group # ____________
Insured's Name ____________
Insured's Soc. Sec. # ____________ Birthdate ____________

## INSURANCE

Secondary Insurance Company
Name ____________
Address ____________
City, Zip ____________
Insurance Co. Phone # ____________
Employer ____________
Union/Local ____________ Group # ____________
Insured's Name ____________
Insured's Soc. Sec. # ____________ Birthdate ____________

## MANAGED CARE PLAN (HM0)

Plan Name ____________ Group # ____________ Plan # ____________
Employer ____________
Insured's Name ____________
Soc. Sec. # ____________

1. **I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.**
2. **By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.**
3. **I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.**
4. **I understand that Bright Now! Dental provides business support services to independent dentists and recognize that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist nor Bright Now! Dental, Inc. or its subsidiaries is responsible for my dental treatment.**

____________
Signature of responsible party or patient (Parent if patient is a minor) Date

**PATIENT FORM - 2**

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