Patient Information

Today's Date:

Name			SSN	
Sex (M/F)	Date of Birth	Marital Status (Circle) M S W D		
Address		City	State	Zip
Home Phone	Work Phone	Cell Phone		
Email Address				
May we leave messages regarding your dental appointments at the above contacts? Home____ Work____ Cell____ E mail____				
Employer Name		Position		

Contact Information To whom may we speak about your dental concerns?

Name	Phone number	Relationship

Dental Insurance Information

Policy Holder Name	**SSN**	**Date of Birth**	**Relationship to Patient**	
Address (if different than above)		City	State	Zip
Employer Name	**Insurance Company**		**ID Number**	
Who else is covered on this policy?				
Name	SSN	Date of Birth	Relationship to Patient	
Name	SSN	Date of Birth	Relationship to Patient	
Name	SSN	Date of Birth	Relationship to Patient	

Who may we thank for referring you to our office?____

Authorize and Release

I authorize Westerville Dental Associates or his agents to perform diagnostic procedures and treatment as may be necessary for proper dental care of myself and/or my child/children.
I authorize release of any information concerning my and/or my child/children's dental care, advice, and treatment to another dentist/doctor.
I authorize release of any information concerning my and/or my child/children's dental care, advice, and treatment provided for the purpose of evaluation and administering claims for insurance benefits.
I hereby authorize payment of insurance benefits directly to Westerville Dental Associates.
I understand that my dental insurance carrier may pay less than the actual bill for services.
I understand I am financially responsible for payments in full of all accounts.
By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid in whole or in part by my dental insurance.
I attest to the accuracy of the information on this document.

____ ____________________________________

Patient or Responsible Party Date