

Designs in Dentistry
Confidential Patient & Responsible Party Information

Patient Name: _____ **Preferred Name** _____ **M / F**
Last First M.I.

Birth Date: _____ **Patient's Social Security #:** _____

Address: _____
Street City State/Zip Code

Home phone: () _____ **Cell phone:** () _____ **Other:** () _____ **E-mail** _____

Emergency contact, outside immediate household: _____ **Phone:** () _____

Relationship: _____
Street City State/Zip

If patient is a minor or dependent, name of parent/guardian: _____
Last First M.I. Relationship

Other family members who are patients of Designs in Dentistry _____

Employment Information

Responsible Party: _____ **Occupation:** _____

Address: _____
Street City State/ Zip Code

(Work): _____ **Ext:** _____ **Hours:** _____ **May we call you at work? Y N** **Driver's License #:** _____

Dental Insurance Information (Primary)

Policyholder: _____ **Relationship to Patient** _____
Last First

Insurance Plan Name and Address: _____

Policy Holder's Birth Date: _____ **SS #:** _____ **Group#:** _____

Policy Holder's Address: _____
Street City State/Zip Code

Policy Holder's Employer Name: _____

Address: _____
Street City State/Zip Code

Is the Patient a full-time college student? If yes, name of college? _____

Is Patient insured under an additional policy? Yes No

Dental Insurance Information (Secondary)

Policyholder: _____ **Relationship to Patient** _____
Last First

Insurance Plan Name and Address: _____

Policy Holder's Birth Date: _____ **SS #:** _____ **Group #:** _____

Policy Holder's Address: _____
Street City State/Zip Code

Policy Holder's Employer Name: _____

Address: _____
Street City State/Zip

How did you learn about our practice?

- Designs in Dentistry** patient (name): _____ **Designs in Dentistry** web site Location
 Newspaper/Magazine _____ Insurance company list /website Other _____

Payment for Services & Notice of Privacy Practices

Payment for dental services is due and payable at the time of treatment. A written financial estimate will be prepared prior to treatment. If you have dental insurance, as a courtesy, we will prepare and submit your dental claims. The patient/responsible party listed above is responsible for all charges, regardless of insurance coverage. I acknowledge receipt of Notice of Privacy Practices.

Signature of patient, responsible party or guardian _____ **Date:** _____ **Relationship to Patient:** _____