誠 Zen
DENTAL GROUP

PATIENT INFORMATION

Patient Information

Name (First): _____ (Middle): _____ (Last): _____ Date of Birth: ____/____/____

Home Address: _____ City: _____ State: ____ Zip: _____

E-mail: _____ Home Phone: _____ Cell Phone: _____

Social Security No: _____-____-_____ Sex: □Male □Female Marital Status: □Single □Married □Separated/Divorced

Employer's Name: _____ Work Phone: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Person: Name: _____ Phone: _____ Relationship: _____

How did you learn about our practice? Please check box.

□ Friend □ Relative □ Dentist □ Physician □ Website □ Telephone Book □ Former Patient □ Other:

Responsible Party

(Parent's/Guardian's Information for Patients who are under 18)

Name (First): _____ (Middle): _____ (Last): _____ Date of Birth: ____/____/____

Is the person listed above currently a patient in our office? □ Yes □ No Relationship to patient: _____

Home Address: _____ City: _____ State: ____ Zip: _____

E-mail: _____ Home Phone: _____ Cell Phone: _____

Social Security No: _____-____-_____ Sex: □Male □Female Marital Status: □Single □Married □Separated/Divorced

Employer's Name: _____ Work Phone: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Information

Insured Name (First): _____ (Middle): _____ (Last): _____ Date of Birth: ____/____/____

Insured Address: _____ City: _____ State: ____ Zip: _____

Patient's Relationship to Insured: □Self □Spouse □Parent □ _____ Insured Social Security No.: ____-___-_____

Employer: _____ Employer's Phone No.: _____

Insurance Company: _____ Insurance Phone No.: _____

Group No.: _____ Policy No.: _____ Effective Date: _____

Secondary Insurance Information

Insured Name (First): _____ (Middle): _____ (Last): _____ Date of Birth: ____/____/____

Insured Address: _____ City: _____ State: _____ Zip: _____

Patient's Relationship to Insured: □Self □Spouse □Parent □ _____ Insured Social Security No.: ____-___-_____

Employer: _____ Employer's Phone No.: _____

Insurance Company: _____ Insurance Phone No.: _____

Group No.: _____ Policy No.: _____ Effective Date: _____

I hereby authorize payment directly to Zen Dental Group for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and /or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistant and other medical personnel.

_____ Signature of Patient

_____ Signature of Responsible Party