

Account # _____

Patient's Name _____ SS# _____ Birth Date _____ Sex _____

How would you prefer to be addressed? _____

Responsible Party _____ SS# _____ Relation to Patient _____

Address (Home) _____ City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Spouse's Work Phone # _____

Email Address _____

If College Student FT PT School _____ City _____ State _____

Insurance Coverage (Must have information in bold)

Employee Name _____

Birth Date _____ **SS#** _____

Employer _____

Name of Ins. Co. _____

Policy # _____

Group # _____

Claim Billing Address _____

Ins. Co. Phone # _____

Individual or Family Coverage _____

Any other dental programs? _____

Secondary Insurance Coverage

Employee Name _____

Birth Date _____ **SS#** _____

Employer _____

Name of Ins. Co. _____

Policy # _____

Group # _____

Claim Billing Address _____

Ins. Co. Phone # _____

Individual or Family Coverage _____

Other persons to appear on this account

Full Name _____ Birth Date _____ Insured By _____

Emergency Contacts

Full Name _____ Address _____ Phone # _____

In consideration of the services rendered to me by this dental office, I am obligated to pay said dental office in accordance with its credit terms and policies. A copy of Bassett Creek Dental's credit terms and financial policies are available upon request.

Patient's Signature _____ Date _____

If patient is a minor, guardian or parent, please sign.