Patient Information

Patient Name:_____ Preferred Name:_____

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

Cell Phone:_____ Home Phone:_____

Email:_____ ☐Married ☐Single ☐Child

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Referred By:_____ Employer:_____

Occupation:_____ Work Phone:_____

Emergency Contact:_____ Phone:_____

Parent / Guardian Information (If under the age of 18)

Parent/Guardian Name:_____ Relationship to child:_____

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

Cell Phone:_____ Home Phone:_____

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Employer:_____ Occupation:_____

Work Address:_____ Work Phone:_____

Insurance Information

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Additional Insurance

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Authorization and Release

I authorize my insurance company to pay Alexander Family Dental all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** Alexander Family Dental may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to the HIPAA guidelines.

Patient/Parent or Guardian Signature **Printed Name** **Date**