FAMILY DENTISTRY
OF CENTRAL CONNECTICUT

Patient First Name _____ Last Name _____

Name you wish to be called_____ Gender M F

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ Able to receive info by text Y N

Work Phone_____ Occupation: _____

Email _____

Birth date_____ SS#_____ Marital Status_____

RESPONSIBLE PARTY INFORMATION

Name_____ Birth date _____SS#_____ Marital Status _____

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ Able to receive info by text Y N

Work Phone_____ Occupation: _____

Employer_____ Employer Phone_____

INSURANCE INFORMATION

Insurance Name_____ Subscriber Name_____ ID#_____

Subscriber Birth Date_____ Subscriber SS#_____ Relationship to patient_____

Do you have dual coverage? Yes No If Yes:

Insurance Name_____ Subscriber Name_____ ID#_____

Subscriber Birth Date_____ Subscriber SS#_____ Relationship to patient_____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____ Relationship_____ Date_____

EMERGENCY INFORMATION

In case of emergency please contact (someone not living with you)

_____ Relationship _____

Address_____ Phone_____