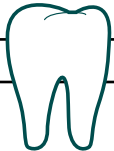


# Welcome



## Patient Information

Date \_\_\_\_\_ ID#/SS# \_\_\_\_\_  
Patient \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Phone (\_\_\_\_\_) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Occupation \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
\_\_\_\_\_



## Phone Numbers

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext Cell (\_\_\_\_\_) \_\_\_\_\_  
Spouse's Work (\_\_\_\_\_) \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_  
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_



## Dental Insurance

Who is responsible for this account? \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me 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

- Estimated co-payments amounts quoted may be subject to change when the final determination of eligibility, deductibles, maximums and contract limitations is made by your insurance carrier. I understand that I am financially responsible for payment of services provided to myself or any member of my family regardless of insurance coverage.
- I understand that photographs taken are the property of Faircourt Dental P.C. and may be used for advertising promotions.
- I understand that treatment will be deemed complete and satisfactory unless our office is notified and scheduled for treatment within 30 days of the final delivery date.

Signature \_\_\_\_\_