Patient Information *(CONFIDENTIAL)*

Date__________________

Title_______Name____ Preferred Name_________________________

Mailing Address____________________________________ Physical Address______________________________

City_________________State_____Zip_______ City______________State______Zip____

Home Phone_____________________ Cell Phone ______________________ Email__________________________

Employer _______________________________ Work Phone_______________________________

Birth Date _____________________ Age_____________ SS#______________________________

If Student, Name of School _____________________ City___________________ State________ Full Part Time

Spouse/Parent Name _________________________ Employer________________ Work #_______________________

Person to Contact in Case of Emergency________________________________ Phone # _____________________

Whom may we thank for referring you? ____

Responsible Party

Name of Responsible Party_____________________________________ Relationship to Patient__________________

Mailing Address____________________________________ Physical Address______________________________

City_________________State_____Zip_______ City______________State______Zip____

Home Phone_____________________________ Cell Phone_______________________________

Employer _______________________________ Work Phone_______________________________

Birth Date _____________ Drivers License # _________________ SS#______________________________

Are you currently a patient in our office? Yes No

SOUTHVALLEY DENTISTRY

Insurance Information

Name of Insured____ Relationship to Patient______________________

Mailing Address____________________________________ Physical Address______________________________

City_________________State_____Zip_______ City______________State______Zip____

Home Phone_____________________________ Cell Phone______________________________

Birth Date _____________ Drivers License # _______________ Work #_______________________________

Employer __________________________ Since ____________ SS#__________________________________

Insurance Co_______________________________ Group # ___________________ Policy/ID#__________________

Mailing Address____________________________________ Ins Co Phone #______________________________

City_________________State_____Zip_______

FEES AND PAYMENTS ***(Fees are due in full at time of service)***

Please remember that insurance *is considered a method of reimbursing the patient for a portion of the fees paid to the doctor and are not a substitute for payment at time of service. If you present us with your insurance information, we will file a claim to them for your reimbursement once payment in full is received.*

I am aware that pre-authorization *and acceptance of submitted dental work to my insurance is not a guarantee of insurance payment.*

I authorize the dentist t*o release any information, including the diagnosis and the records of any treatment of examination rendered to my family or me during the period of such dental care, to third party and/or health practitioners, by mail or electronic transmission, in accordance with the HIPAA Privacy Rule.*

I have read the office policies *as noted above for South Valley Dentistry and I agree to be responsible for payment of all services and charges in this office rendered on my behalf or for other members of my family.*

Patient/Responsible Party Signature ____ Date _______________