FOCUS DENTAL
NURTURING HEALTHY SMILES

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PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help.

Name: _____
Last First MI

Preferred Name: _____ Male ❑ Female ❑

Address: _____ City _____ State ____ ZIP_____

SSN: _____ DOB:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ E-mail Address: _____

Employer:_____ Occupation: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

How did you hear about our office?_____

Do you prefer to be contacted for appointment confirmation via ❑ e-mail or ❑ phone?

Insurance – Primary ***Please present insurance card to receptionist***

Subscriber Name: _____ Relationship to Patient: ❑Self ❑Spouse ❑Child

Subscriber SSN/ID: _____ Subscriber DOB: _____

Insurance Company Name: _____ Subscriber Employer:_____

Insurance Company Address:_____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: ❑Self ❑Spouse ❑Child

Subscriber SSN/ID: _____ Subscriber DOB: _____

Insurance Company Name: _____ Subscriber Employer:_____

Insurance Company Address:_____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Focus Dental 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 payments of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Consent - I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

_____ _____
Patient/Guardian Signature Date