Auburn Centre Dental

Patient Information

DATE: _____

PERSONAL INFORMATION

Name: _____
MR ● MISS ● MRS ● MS ● DR ●

Prefers To Be Called: _____

Date of Birth: DAY _____ MONTH _____ YEAR _____

Home Address: _____

_____

_____

Home Phone: _____

Cell Phone: _____

Email: _____

Business Address: _____

_____

_____

Business Phone: _____ Ext: _____

Occupation: _____

May we call you at work: YES ● NO ●

In case of emergency we should notify

Name: _____
MR ● MISS ● MRS ● MS ● DR ●

Relationship: _____

Daytime Phone: _____

Family Physician: _____

Phone and Address: _____

_____

Medical Specialist (1): _____

Area Of Specialty: _____

Phone and Address: _____

_____

Medical Specialist (2): _____

Area Of Specialty: _____

Phone and Address: _____

_____

How did you hear about our office : _____

INSURANCE INFORMATION

Primary Insurance Company: _____

_____

Subscriber's Name: _____

Date of Birth: DAY _____ MONTH _____ YEAR _____

Employer: _____

Group Policy Number: _____

Division Number: _____

ID / Cert. Number: _____

Secondary Insurance Company: _____

_____

Subscriber's Name: _____

Date of Birth: DAY _____ MONTH _____ YEAR _____

Employer: _____

Group Policy Number: _____

Division Number: _____

ID / Cert. Number: _____

I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Signature of Patient, Parent, or Guardian: _____ Date: _____

* Please note: our relationship is with you, not your insurance company. The relationship you have with your insurance company is your responsibility.

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