Welcome!

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

ID/SS#_____

Name_____Birthdate_____/_____/_____

Address_____City_____State_____Zip_____

Home(____)_____Cell(____)_____Work(____)_____

Single____Married____Spouse or Parent/Guardian's Name_____

Whom May We Thank for Referring You?_____Email_____

Person to Contact in Case of Emergency_____Phone(____)_____

Physician Name_____Phone #_____Last Physical_____/_____/_____

Insurance Information

Name of Insured_____Relationship to Patient_____

Birthdate_____/_____/_____ID/SS#_____Policy ID#_____

Employer_____Ins Comp_____

Responsible Party

Name of Person Responsible for this Account_____DOB_____/_____/_____

Relationship to Patient_____ID/SS#_____

Address_____City_____State_____Zip_____

Home(_____)_____Work(_____)_____Employer(_____)_____

Other Responsible Parties: Please provide us with a list of any person over the legal age of 18 who may bring your minor to future appointments. Persons on this list may accompany minors to our office but only legal guardians can sign consent for treatment.

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I understand, that as a courtesy, Allred Family Dentistry files for insurance payment. I hereby authorize payment of the insurance benefits (otherwise payable to me) directly to this office. I also understand that I am responsible for payment of services rendered and also responsible for paying any co-payment, balance, and/or deductibles that my insurance does not cover.

Signature_____Date_____/_____/_____